A Case Study within the Department of Social Services (DSS)

Findings Part One: Pre-Adoption, 1998-2001 and Daycare section
Findings Part Two: Post-Adoption, 2001-2005 and MassHealth section
Attachments

A report to the

The Massachusetts
House of Representatives

Committee on
Post Audit and Oversight

June 2006

The committee shall oversee the development and implementation of legislative auditing programs to be conducted by its bureau with special emphasis on performance auditing. The committee receives the reports of the department of the state auditor and the legislative auditors and shall determine what remedial measures, if any, are necessary. The committee shall have the power to summon witnesses, administer oaths, take testimony and compel the production of books, papers, documents and other evidence in connection with any authorized examination and review. If the committee shall deem special studies or investigations to be necessary, they may direct their legislative auditors to undertake such studies or investigations.

Massachusetts General Laws:
Chapter 3, Section 63

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June 13, 2006

Honorable Geoffrey Hall
Chairman, House Committee on Post Audit and Oversight
MA State House, Rm. 146
Boston, MA 02133

Dear Chairman Hall:

The Department of Social Services has received the Report of the House Post Audit and Oversight Committee. The Report is thorough, exhaustive and deeply informative to the fundamental revision of child welfare practice which the Department is currently engaged in.

We are concerned, however, that the body of the Report contains considerable confidential information concerning the child's case that might very well be inappropriate for public release. The release of this information into the public domain could be profoundly compromising to the child's well-being and right to privacy.

We, therefore, respectfully request that the Committee refrain for the present from releasing the body of the report, which contains extensive, detailed case information, until the Department has the opportunity to work with your Committee, the Bureau and House Counsel to ensure that any release respects the confidentiality limits that should apply in this case, while ensuring proper public review and oversight of the Department's actions.

Thank you for your consideration in this matter.

Respectfully,

Lewis H. Spence

Lewis H. Spence
Commissioner

A Case Study within the Department of Social Services (DSS)

A report to the
The Massachusetts House of Representatives
Committee on Post Audit and Oversight

Synopsis of Report

Recommendations

Findings (Pre-Adoption 1998-2001)
Daycare (Pre-Adoption volume one)

Findings (Post-Adoption 2001-2005)
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Methodology

Family Relationship Chart

List of Attachments (included)

- Social Security Administration correspondence regarding multiple social security numbers for the CHILD
- Letter from Local 509, Service Employees International Union regarding CHILD and the previous recommendations from earlier reports regarding the Department of Social Services.
- Letter regarding "end of life issues" sent to Governor Romney and Speaker DiMasi
- Care and Protection of Sharlene, Massachusetts Supreme Judicial Court , SJC-09629, December 6, 2005-January 17, 2006
- DSS Response to "A Case Study within the Department of Social Services (DSS)"

A Case Study within the Department of Social Services (DSS)

A report to the House Committee on Post Audit and Oversight from its Bureau

Dear Chairman Hall, Vice Chairman Costello, and Members of the HPAO Committee:

As requested by the Speaker of the Massachusetts House of Representatives and the House Committee on Post Audit and Oversight (HPAO), the Committee's Bureau submits this report, a case study, regarding a severely beaten CHILD in Western Massachusetts and this CHILD's involvement with the Massachusetts Department of Social Services.[1]

To explain this complicated case as clearly as possible to the House Committee on Post Audit and Oversight, the HPAO Bureau divided the report into two sections. An initial section dealing with the CHILD from custody by DSS in mid-July 1998 through her adoption in mid-October 2001; while a second section addresses relevant issues in the CHILD's adoptive life until her hospitalization after a severe physical assault that placed the CHILD in a coma.[2] In addition the two sections include two additional parts as follows:

1. **Findings from the Pre-Adoption of the CHILD (1998-2001)**
   - **Section and Findings on Daycare arrangements for the CHILD**

2. **Findings from the Post Adoption of the CHILD (2001-2005)**
   - **Section and Findings on the Medical and Mental Health Services for the CHILD**
   - **Recommendations**
   - **Attachments**
   - **Agency Commentary (if any)**

In late January 2006 the House Post Audit and Oversight (HPAO) Committee was requested by the Speaker to thoroughly inquire into a widely reported case involving child abuse and neglect. This case study examines the circumstances and events of a CHILD: who came into the care and custody of the Massachusetts Department of Social Services (DSS) in July 1998, due to allegations of sexual abuse; who became a foster child in a "kinship placement;" who was adopted and left DSS custody; who lived with her adoptive family while receiving many state supported or state provided services; who was suspected of "self-abuse" by various professional service providers; who was both treated professionally, emotionally, and medically and who was monitored by these providers; and who, four years after her adoption, was rushed to a Western Massachusetts hospital in a coma due to vicious physical abuse. Her adoptive mother

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[1] The references to persons in this report, although some are widely known due to media coverage, are referred to anonymously. Thus, the victim is always the "CHILD" in upper case letters. Similarly, other references to persons are by a description that corresponds to either their occupation or relationship to the CHILD rather than their personal name.

[2] The HPAO Bureau also notes that it released a report on DSS in October, 1998, or about the same time the CHILD was entering DSS custody. That 1998 report found many of the concerns noted in the first time period of this case study, such as collateral shortcomings, large workloads, concerns about supervision including the supervision of, inexperienced caseworkers, communications issues, and a need for more contact with the District Attorney and the police.

and her second husband were subsequently arrested for criminal assault upon a child. The mother was found dead eleven days later.

Upon receipt of the Speaker's request the Committee issued subpoenas duces tecum for the production of documents and instructed its Bureau to begin an examination immediately. This case study is that examination. This report is based upon the documents made available to the Bureau through the summons power of the Committee augmented by interviews and other fact finding tools. The Bureau's methodology process is explained in an adjoining section.

Contributing to the notoriety of the CHILD's case is the finding by medical professionals that the CHILD suffered irreparable brain injury and she should "not be resuscitated on the occurrence of cardiac or respiratory failure."[3] Motions for "Do Not Resuscitate" (DNR) and the removal of the CHILD's feeding tube were filed with the Massachusetts Juvenile Court. A Massachusetts judge found that the CHILD's "dignity and quality of life would be most respected by withdrawing both the ventilator and the feeding tube along with the issuance of a [DNR] order, with great sadness I so issue this day."[4] The case records were sealed. The defendant appealed and the case was heard by the Massachusetts Supreme Judicial Court (SJC) with an opinion released on 17 January 2006. A copy of the SJC opinion is attached. Also attached is correspondence, forwarded to the HPAO Bureau, from a co-counsel to the defendant. The HPAO Bureau is not reporting on this "end of life" legal aspect of the case, other than by noting and appending the attachments.

Almost immediately upon examining the first production of documents the HPAO Bureau realized that for the CHILD's case to be properly understood required separating the case of the CHILD into two distinct parts: a pre-adoption phase, and a post-adoption phase. The CHILD's case – which is both complicated and convoluted in its fact pattern - could not be easily comprehended without that separation. Even with this separation, the case remains extremely complicated.

This report is a single case study. Expressed in current case terms it was one of almost 1600 cases in the Holyoke area office of DSS.

In the last quarter fiscal year 2005, and in the first quarter fiscal year 2006, the DSS had 23,490 open cases, and 22,592 open cases respectively.[5] To service these DSS cases there are 2848.04 "Full Time Equivalents" (essentially full time persons) including Social Work Technicians, Social Workers, Social Work Supervisors, Managers, Administrative Staff, and Clerical Staff. Of these FTEs in the DSS, there are 2,101.12 FTEs who are social workers. The largest FTE region of DSS is the Southeast Region; the second largest FTE region is the Western region.[6] The CHILD was a foster child in the Western Region in the Holyoke area office.

[3] "Care and Protection of Sharlene," SJC-09629, December 6 2005-January 17 2006 (from a "Civil Action commended in the Supreme Judicial Court for the county of Suffolk on October 7, 2005), p.5.

[4] Ibid., p. 6

[5] Department of Social Services Quarterly Report Fiscal Year 2005, 4th quarter, Commonwealth of Massachusetts, Data Management/Quality Assurance Information Technology, December 2005; Department of Social Services Quarterly Report Fiscal Year 2005, 4th quarter, Commonwealth of Massachusetts, Data Management/Quality Assurance Information Technology, March 2006.

[6] Spreadsheet, Area Office Staff FTE Report, Mass. Department of Social Services, 15 April 2006 (supplied to the HPAO Bureau on 1 May 2006 by electronic mail).

Of the total DSS case load, the Holyoke area office was reported to have a total child caseload of 1810 in December 2005, and 1591 in March 2006. There are 86.40 FTE social workers in the Holyoke area office.[7] In reviewing this case study it is important to keep in perspective that DSS case load and individual clients are not synonymous, since a single case could have one or more clients. When HPAO interviewed social workers for this report, and asked those workers how many cases each individual was responsible for, the response was between 18 – 22 if the social worker was "ongoing" as opposed to investigative, or an assessment social worker. Investigative or assessment social workers carry a lighter but weighted case load; an investigative case, for example, is regarded as having an equivalent value of 1.5 as compared to an "ongoing" case which has a value of 1. Thus, investigative workers had a customary caseload of 12 -14, the HPAO Bureau was told.

This issue of caseloads is a contentious one, and the HPAO Bureau treated this situation with greater detail in its 1998 Preliminary Report on the Department of Social Services.[8] In that same report, the Bureau reported on collateral contact for comparative fact gathering, increasing the non-emergency investigation time from 10 calendar days to 15 business days, the recommendation that there be a requirement to report substantial injury to the District Attorney and to the police, and the advent of the Statewide Automated Child Welfare System (SACWIS) was described. The DSS called this SACWIS system "FamilyNet." Automating child welfare was a great improvement and the case of this CHILD is documented on FamilyNet. However, FamilyNet still has limitations of scope and content. The reader is directed to the HPAO Bureau's 1998 report on the DSS for further information on those findings and recommendations of eight years ago.

This report to the HPAO Committee is a case study and not a universal application to all DSS cases. Rather, this report offers a fact-based means to compare and contrast the issues confronted in this case by the Department of Social Services against all of the cases, situations, circumstances, and events which confront the DSS on a daily basis. Thus, this case study should serve as a foundation for an informed understanding of DSS. The Bureau offers this case study in as much detail as was possible (see methodology). The Bureau believes that using this case study as a basis to both understand and discuss DSS is beneficial. It is the Bureau's hope that this case study and the information within it can be used to invigorate an informed discussion and a progressive improvement of the Department of Social Services. Any effort based upon a candid and informed discussion can only translate into better protection for the Commonwealth's children.

Efforts to revamp the child welfare system in Massachusetts have been suggested before. Indeed, thirteen years ago a three volume report on child welfare and foster children was issued under an executive order of the Governor of the Commonwealth of Massachusetts.[9] As the Massachusetts social workers' union representative reminded the HPAO Bureau, many current recommendations that would revitalize, improve, and strengthen child welfare and child

[7] Ibid.

[8] See: Preliminary Report: Department of Social Services (DSS), House Post Audit and Oversight Bureau, 1998, Mass. House of Representatives, State House, Boston. 73p.

[9] "Special Commission on Foster Care," 3 volumes, issued: February, 1993. The Special Commission on Foster Care was established by Executive Order on 26 March 1992

protection were suggested in 1993 by that "Special Commission on Foster Care."[10] The union's letter to the HPAO Chairman and HPAO Committee members is attached to this report.

The Bureau too finds the decision regarding Sharlene (who is the CHILD of this report) issued by the Massachusetts Supreme Judicial Court in mid-January to be both thoughtful and beneficial; it is particularly noteworthy where the SJC opinion states "we, as a society need to do more to aid children who are neglected and abused, and hereby denied the care and nurturing they so desperately want and need…and that [this case] helps other children to escape their misery."[11]

The CHILD of this case study and report received many services from the Commonwealth, and from private providers; however, and as this case study demonstrates, the overarching problem was a ***systemic*** lack of coordination and communication and at certain moments a failure of certain persons to fully do their jobs for whatever reason. But the root problem is systemic. In the later period of this case study, the system turned DSS and the service providers into antagonists rather than advocates for this CHILD. Too often oversight, collateral contact, and the effectiveness of the services to the CHILD and her family were either poorly conducted, or not conducted at all.[12] Therefore, and again, the best use of this report is to apply it to examine the facts closely, understand why this systemic failure occurred, and set to work to remedy the identifiable, systemic short-comings and obstacles to child welfare. By necessity any effort to correct systemic failings must be an endeavor attended to by a multitude of persons, agencies, persuasions, and interested organizations.

It also should be understood that across the threshold of the DSS offices throughout the state each day arrive an array of society's problems. When these societal difficulties are further associated with raising children, protecting children from a multitude of harms, and generally providing for a child's welfare, these societal troubles conspire to test the will, the courage, and the ability to persevere of our strongest citizens. The social worker is often out in the community alone and left to ponder in mere minutes solutions to problems which have developed over years. That is the present practical reality to social work. This study of this case should ponder how to better address these societal dilemmas present in some form or other well before this Commonwealth was established. It will take great effort to achieve progress; to use this case study as a means to find a person or persons to blame so that this systemic issue will temporarily go away, is to misuse this report. The challenge is to use these report findings to reduce the frequency of the abuses and deceptions visited upon the CHILD to as close to zero as is humanly possible.

To be effective, this case study should be utilized as something more than a recitation of failures within a single tragic case. Rather, understanding the facts of this case can and should lead to the next step: constructive inquiry and response. That next step should ask: what do the facts of this case reveal about the DSS system? And, too, the system of child welfare beyond DSS? What questions should be raised about these systems based on fact-finding? What systemic practices should be confronted? For example, there were often in the documents

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[10] Ibid.

[11] "Care and Protection of Sharlene," SJC-09629, December 6 2005-January 17 2006 (from a "Civil Action commended in the Supreme Judicial Court for the county of Suffolk on October 7, 2005), p. 9.

[12] See: Preliminary Report: Department of Social Services (DSS), House Post Audit and Oversight Bureau, 1998, Mass. House of Representatives, State House, Boston. 12 – 14 p, 33p., 40 p.

misunderstandings of what constitutes "fact" itself. Some documents reviewed had the facts utterly jumbled or sloppily attributed. Poor fact gathering is a pre-ordained prescription for failure. In other documents, verbal attestations made as statements were institutionalized in their re-telling so that they were treated as fact. Statements are not facts in themselves. Statements can be attributed and the attribution may be a fact in that the statement's speaker is paired to the spoken statement; but the integrity of the statement is not necessarily a fact. Thus, I may say the world is flat; but that does not make the world flat. Facts are objective realities which can be verified. Collateral contacts, for example, seek to verify statements factually. To the Bureau, it appears that there needs to be some consensus within DSS on fact finding, and how to route out fictions posing as fact. And too, what verifications are critical? Is documentary verification essential to determine services and benefits? The Bureau was told on several occasions that statements made by persons receiving services are taken factually and that misrepresentations by persons seeking aid were unlikely because the person seeking services and assistance would tend toward telling the truth. That was not true in this case study. In some cases (Collaborative Assessment Program, for example) documentary verification is not utilized? Is that a prudent policy? In this case it was not. It was in review of the CAP document that the HPAO Bureau discovered the first of what were multiple social security numbers for the CHILD. (See attached letter to and from the Social Security Administration). Yet, the Bureau was told, there is a concern among social workers that extensive utilization of documentary verification will discourage clients from seeking help, and discourage the recruitment of foster and adoptive parents. Is that a certain result of more detailed verification? The Bureau is skeptical.

To what degree is even "ongoing" social work really investigative or fact-finding? After interviewing many social workers, the Bureau believes the fact-finding process is integral to their work. And what is the best way to approach social work? Is it a solitary profession, or should it always be done as a team? The Bureau has heard about the benefits of teams, and yet each statement advocating "team" approaches has a differing definition of what the word "team" means. The Bureau supported the team concept in its 1998 report, and the Bureau continues to believe that more eyes, ears, and insights are better. However, the Bureau suggests a more focused definition and communication of the team concept. These are but a few of the questions that arise from this case study. More questions need to be asked. Among the Bureau's recommendations are that this report be distributed both to other legislative committees and to all of the Massachusetts Schools of Social Work; the purpose of the distribution is to encourage more discussion, inquiry, response, and endeavor for child welfare.

Child welfare and social work are difficult occupations. This case study illustrates the difficulty confronting DSS to greater and lesser degree in its 20,000 plus cases. In both parts of this case study it is evident that the social worker(s) and the provider(s) were confronted with a clientele with a very troubled past and an intentionally deceptive agenda. This case sounds another warning bell for the Commonwealth of Massachusetts. Yet, there must be a better way. What that way is depends upon the steps that are taken after this case study is read and absorbed.

Recommendations For
A Case Study Within The Department of Social Services

1. **Strengthen and streamline the mandated reporting system.** Require that mandated reporters receive initial and ongoing training. Consider online education and training, including the development of strategic partnerships with Massachusetts educational institutions. Increase penalties and enforcement of penalties for failure to report child abuse/neglect.
2. **Develop and implement a high-risk assessment tool.** Design an objective and effective tool or instrument to identify and monitor those children in need of increased attention and careful management.
3. **Improve educational requirements for social workers.** Institutions of higher education should require more outside-the-classroom training for students pursing a degree in social work.
4. **Establish an audit unit that reviews processes and cases and reports directly to the DSS Commissioner.** Staff audit unit with persons qualified by education and expertise who can assess whether cases are being managed effectively and appropriately.
5. **Increase law enforcement involvement in child abuse/neglect cases.** Require earlier notification of the local district attorney and police officials in additional circumstances of child abuse/neglect, such as the leg burns and the negligent care of a child with alleged homicidal tendencies and self-abuse as described in this case.
6. **Codify and make public the end-of-life decision-making process.** If decisions are to be made about withholding or withdrawing life support from children in the custody of DSS, that process should be thorough, clear and open to public scrutiny.[13]
7. **Improve DSS records management systems.** Implement changes to guard against fragmented, disjointed and poorly managed record-keeping so that a child's situation can be readily and comprehensively assessed by DSS and, if appropriate, the courts.
8. **Improve coordination with MassHealth.** Services provided to DSS-involved families through MassHealth should be monitored to ensure better management and oversight.
9. **Transmit this report to the Commonwealth's schools of social work.** Inform those who train social workers and social workers themselves about the details of this case study so it can be used as a teaching tool.
10. **Distribute this report to legislative committees handling child welfare and protection issues and related financial and budgetary matters, to the Governor, and to the State Auditor.**

[13] See Care and Protection of Sharlene, 445 Mass. 756.

HPAO Findings: 1998 - 2001
Part One of Two Parts

Finding A. Legal Custody by DSS

The Bureau found that, in July of 1998 and at various other points, the role, responsibilities and obligations of DSS as the court appointed legal custodian of the CHILD may not have been fully clarified, understood and enforced by all of the DSS personnel involved in the case.

Finding B. Unsubstantiated Allegations of Self Injurious Behavior by the CHILD

For the entire period of nearly three and one half years, in reviewing case worker documents and dictation notes, medical records, psychiatrist reports, clinical psychologist reports and therapist treatment notes and via discussions with DSS personnel and two of the therapists, the Bureau was unable to find any formal reference to and/or first hand corroboration of self-injurious behavior by the CHILD other than three uncorroborated verbal reports made to case workers by the Foster/Adoptive Mother and her First Husband.

Finding C. Placing the CHILD in Harm's Way

The Bureau found that, from July of 1998 to January of 1999, a lack of continual oversight and integrated case management by DSS personnel may have, in one case, unduly placed the CHILD in harm's way.

Finding D. Emergency Care Situation; Unattended Dental Needs

The Bureau found that, for the period from July of 1998 to May of 1999, or nearly ten months, as legal custodian for the CHILD, DSS did not initiate an immediate response to an emergency medical situation, i.e., required dental care.

Finding E. 51A Reports and 51B Investigations; Anonymous Letter; Collaterals

The Bureau found, in April of 2000, a serious shortcoming within DSS concerning what should be done in the 51A report and 51B investigation process and what was actually done by case workers on one occasion involving an anonymous letter sent to DSS which included allegations concerning the welfare of the CHILD.

Finding F. 51A Reports and 51B Investigations, Physical Assault

The Bureau found, in December of 2000, another serious shortcoming within DSS concerning what should be done in the 51A report and 51B investigation process and what was actually done on an occasion involving an allegation by the CHILD of physical assault on her person by the Foster/Adoptive Mother's First Husband.

Finding G. Foster Parent Aide; Serious Concerns

The Bureau found that a Foster Parent Aide assigned to the case by DSS for a very short period of time in early 1999, had shared with case workers, her misgivings and serious concerns about the Foster/Adoptive Mother. This Foster Parent Aide had been asked to assist the Foster/Adoptive Mother less than one year after DSS had assumed legal custody of the CHILD.

Finding H. DSS Visits to the Home of the Foster/Adoptive Parents

The Bureau found that, for the period from July 13, 1998 to October 21, 2001, or nearly three and one half years, monthly home visits by case workers to the home of the Foster/Adoptive Parents were not consistently fulfilled and may not have been frequent enough considering the CHILD'S case history.

Finding I. Therapy Sessions; Calendar

The Bureau found that, for the period from July 13, 1998 to October 21, 2001, the CHILD'S therapy sessions were not initiated and subsequently scheduled and fulfilled in a timely and consistent manner. Oftentimes therapy sessions were missed, cancelled or intermittent.

Finding J. Summary Content of Therapy as Provided by Therapist #1

The Bureau found, in a review of case worker dictation notes and other records and via a discussion with the therapist, that during the course of the thirty-one therapy sessions conducted by Therapist #1 from 8/26/98 to 8/12/99, a number of concerns were raised or incidents occurred that should have been viewed by the case workers as possible warning signs concerning the viability of the Foster/Adoptive Mother and her First Husband to be adoptive parents. At the same time, Therapist #1 never observed self-inflicted injurious behavior or other questionable acts, such as lying, on the part of the CHILD.

Finding K. Summary Content of Therapy as Provided by Therapist #2

The Bureau found, in a review of therapist treatment notes, case worker dictation notes and other records and via a brief discussion with the therapist, that during the course of the sixty-five therapy sessions conducted by Therapist #2 from 8/23/99 to 12/21/00, although a number of allegations were raised during the course of the therapy, Therapist #2 very rarely performed collaterals to prove or disprove the validity of these statement be they made by the CHILD and/or by the Foster/Adoptive Mother. At the same time, Therapist #2 never observed self-inflicted injurious behavior or other questionable acts on the part of the CHILD.

Finding L. Monthly Office Visits by Foster Parents (in conjunction with the CHILD'S Therapy Sessions)

The Bureau found that, for the period from July 13, 1998 to October 21, 2001, or nearly three and one half years, periodic Foster/Adoptive Parents office visits with the CHILD'S therapists were not initiated, subsequently scheduled and fulfilled in a timely and consistent manner.

Finding M. Therapist Records; Integrity

In the case of Therapist #2, the Bureau found very serious inconsistencies in the documentation of the CHILD'S therapeutic sessions including: content discrepancies between reports; substantive comments left out of reports; and, reports that had been completed, reviewed and approved well after the fact.

Finding N. Supervised (by DSS) Parental Care Visits by Biological Mother

The Bureau found that, for the period from July 13, 1998 to October 21, 2001, monthly parental care visits with the CHILD by the Bio-Mother were not scheduled and/or fulfilled in a timely and consistent manner and were, at times, inconsistently managed by case workers.

Finding O. Unsupervised (by DSS) Parental Care Visits by Biological Mother

The Bureau found an utter and complete disregard by the Foster/Adoptive Parents of court orders and explicit DSS instructions pertaining to unsupervised visits with the CHILD by the Bio-Mother, i.e., these types of visits were not to be permitted under any circumstance.

Finding P. DSS Home Visits with Biological Mother

The Bureau found that, for the period from July 13, 1998 to October 21, 2001, home visits by case workers to the Bio-Mother's home were, for all practical purposes, non-existent.

Finding Q. Inconsistent or Questionable Reports

The Bureau found instances where information reported or statements made to case workers and/or service providers was inconsistent or questionable.

1. Inconsistent descriptions by the Foster/Adoptive Mother of the CHILD'S appearance upon the CHILD'S first arrival at the Foster/Adoptive Mother's home.
2. Inconsistent statements, both written and verbal, as to whether or not the CHILD has ever met or been seen by her Bio-Father.
3. Questionable circumstances concerning the CHILD'S living conditions at the Foster/Adoptive Parent's new house.
4. Inconsistent statements and questionable reports concerning the CHILD'S relationship and/or unsupervised interaction with the Bio-Mother and the Bio-Mother's new baby (CHILD'S half brother).

Daycare Findings (1998-2003)

Finding A. Foster/Adoptive Mother twice requested and twice refuses DSS paid/subsidized Day Care.

Finding B. Perplexing and Contradictory Actions.
Foster/Adoptive Mother complained about the cost of the CHILD's day care, yet when offered DSS paid day care she declined the offer.

Finding C. DSS allowed CHILD to be placed in daycare without its consent while CHILD was in DSS custody.

Finding D. Daycare locale and placement of CHILD withheld from DSS by Foster/Adoptive Mother.
DSS had custody, not Foster/Adoptive Mother

Finding E. Possible Unsupervised visits between CHILD and her Bio-Mother, contrary to DSS foster care instructions.

Finding F. Foster/Adoptive Mother was licensed by the Massachusetts Department of Early Education and Care from 1991-2003 (She voluntarily surrendered her license in 2003).

HPAO Findings: 2001 – 2005
Part Two of Two Parts

Finding A. Inconsistencies in Foster/Adoptive Mother's Interactions:

The HPAO Bureau found many inconsistencies in the Foster/Adoptive Mother's statements to DSS, Providers, Medical Personnel and Schools.

Finding B. Selective Reporting to DSS by Providers:

The HPAO Bureau found selective reporting of incidents and neglect to DSS by the Providers, and found school/teachers, and medical providers resistant to DSS and displaying a persistent affiliation or identification with Foster/Adoptive Mother.

Finding C. 51As (Chart Included):

Number of 51A's filed before September 11, 2005: There were twenty-two total 51A reports filed on this family before September 2005 that HPAO is aware of. Nine of these reports cover four incidents. (More than one report was filed for four different incidents.) Fifteen 51A reports were filed **just** for CHILD.

The HPAO Bureau found fourteen 51A reports related to CHILD from her adoption in October 2001 upto her hospitalization in September 2005.

Finding D. 51B Investigations:

The HPAO Bureau found six 51B Investigations done on this family between October 2001 and September 2005.

Finding E. Communication and Integration (False Social Security Number's Discovered):

The HPAO Bureau found that DSS Communication and Integration needs improvement including: Teamwork; Documentary Review; FamilyNet; Agency Integration; Audit Function; Record Management; Provider oversight.

Finding F. Collaterals:

The HPAO Bureau found that DSS collaterals – or a process for comparative fact gathering - in this case were not as thorough as they should have been.

Finding G. Providers Meeting on August 24, 2005:

The HPAO Bureau found that when DSS attempts to place CHILD in residential care the Providers actively and collectively opposed the placement.

Finding H. State Providers Exclude DSS, Drive Treatment and Incur Treatment Cost with Little Apparent Oversight and a Disregard of Mandated Reporting- 2002-2005:

The HPAO found little oversight of Providers regarding filing abuse/neglect reports, service quality and costs.

Finding I. Home Visits - "Voluntary Services" and Investigations:

The HPAO Bureau found problems with DSS home visits including: unscheduled home visits; scheduled home visits; Foster/Adoptive Mother who rescheduled many home visits; Foster/Adoptive Mother controlled the home visit schedule.

Finding J. Level of Supervision for a "Self-Abusive Child":

The HPAO Bureau found many instances where Foster/Adoptive Mother's level of supervision was called into question without adequate corrective action, instances where it should have been called into question, and Providers not calling Foster/Adoptive Mother's level of supervision into question.

Finding K. Mandated Reporters:

The HPAO Bureau found Mandated Reporters dismissal of possible child abuse or neglect incidents; and found failures to report such incidents to DSS and/or law enforcement. It is unclear if such dismissal and failures are due to poor judgment calls, disregard for the legal responsibilities of mandated reporters; and/or some other failure.

Finding L. The CHILD and the Collaborative Assessment Program (CAP):

The HPAO Bureau further found Mandated Reporters not reporting, taking 4 months to complete a CAP referral, 2 months for the CAP Assessment to be completed, 12 months for the whole process to be completed (average CAP is 21 days to complete), CAP allowing itself to be stalled by Foster/Adoptive Mother and CAP not checking and verifying documents.

MassHealth Findings

Finding A. MassHealth and Massachusetts Behavioral Health Partnership (MBHP) provided health benefits to CHILD.

Finding B. The benefit coverage provided was comprehensive and offered a wide range of services to CHILD as a member.

Finding C. MBHP dealt with the claims submitted, however, there is no evidence that MBHP or MassHealth conducted any quality control with the member or the provider.

Finding D. Based on the documents provided to HPAO by MassHealth, MBHP, and DSS, there were many cancelled or missed therapy and psychiatric (medication monitoring) sessions. The documents also portray a lack of follow-up regarding cancelled or missed sessions.

Finding E. Post-adoption therapy sessions began in October 2002 due to a concern of the CHILD's refusal to attend school. Therapy escalated to hospitalization within two months.

Finding F. From August 2000 to September 2005, the CHILD was prescribed six different medications by multiple psychiatrists as part of her treatment plan.

Finding G. The sporadic attendance at the psychiatric sessions throughout the service plan, coupled with the various medications prescribed to CHILD, made it difficult to monitor the medical effects on a child of her age. HPAO Bureau has a concern about oversight.

Finding H. The CHILD was hospitalized on five separate occasions for several differing diagnoses, according to the documents. See hospitalization schedule.

Finding I. The family did not adhere to the service plan proposed by the Carson Center and authorized by MBHP.

Methodology

Pursuant to G.L. c. 3 §63, the House Post Audit and Oversight (HPAO) Committee issued subpoenas duces tecum for the production of documents from DSS, MassHealth and Department of Mental Health. Other state agencies (e.g., Department of Early Education and Care) were solicited for information that assisted in the HPAO Bureau fact finding.

HPAO Bureau also conducted a series of interviews in person, on the telephone, and by electronic mail. The interviews included persons who played substantial roles in the case from 1998-2005, and who were generally identifiable according to the documents. Interviews were also conducted of providers on a voluntary basis using the same standard. All providers who were able to be located and were identified in documents as having significant roles were offered an opportunity to comment. The HPAO Bureau is aware that there is an ongoing criminal investigation related to this matter. The Bureau did not contact any person that it believed may have a direct relationship to the investigation. Every attempt has been made to distinguish between fact and opinion.

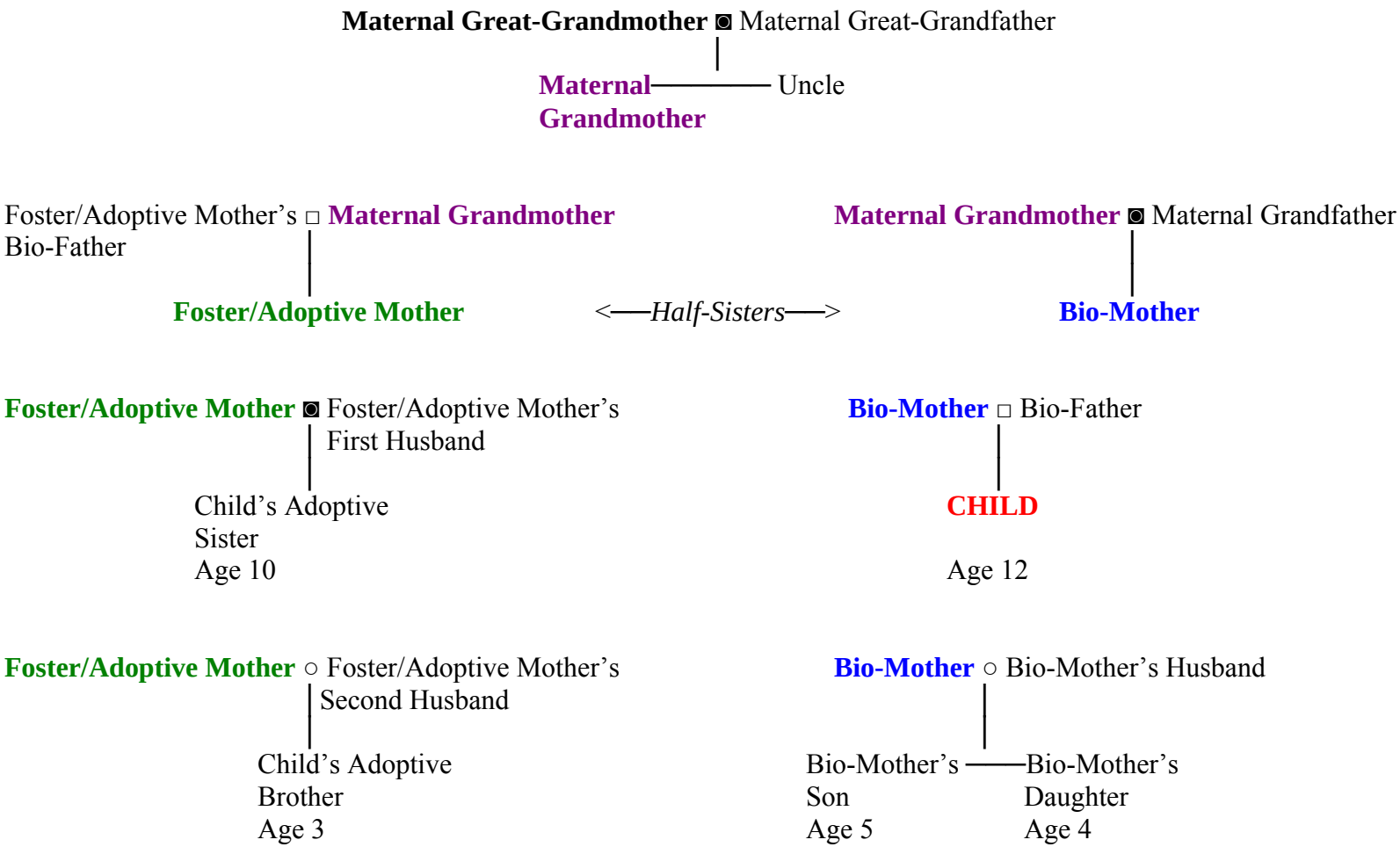
At the conclusion of the documentary review and the interviews, including clarifications and requests for corroborating or missing documentation, the HPAO Bureau had a lengthy discussion of the case, the documents, and the interviews with DSS personnel and with the DSS Commissioner and DSS Deputy Commissioner.

The HPAO Bureau also requested various financial documents from both MassHealth and DSS. After the review of the requested documents, the HPAO Bureau interviewed the chief financial officer of the DSS, various personnel at MassHealth, and the chief executive officer of the Massachusetts Behavioral Health Partnership (MBHP).

In the course of its examination, many persons and individuals contacted the HPAO Bureau. Those persons who called and expressed opinions were requested by the Bureau to put those opinions in writing. The Bureau attaches to this report the two written comments it received.

Finally, the HPAO Bureau in the course of its documentary review did find multiple social security numbers for the CHILD. The HPAO Bureau immediately notified the United States Social Security Administration (SSA) and appropriate law enforcement of this discovery.

CHILD Family Tree*



Maternal Great-Grandmother adopted Foster/Adoptive Mother; Foster/Adoptive Mother adopted CHILD

○ = Married
◙ = Divorced
□ = not married

**based on multiple and various newspaper reports*

Attachments
[Appended to **Part Two: Post-Adoption, 2001-2005**]

- Social Security Administration correspondence regarding multiple social security numbers for the CHILD

- Letter from Local 509, Service Employees International Union regarding CHILD and the previous recommendations from earlier reports regarding the Department of Social Services.

- Letter regarding "end of life issues" sent to Governor Romney and Speaker DiMasi

- Care and Protection of Sharlene, Massachusetts Supreme Judicial Court , SJC-09629, December 6, 2005-January 17, 2006

- **DSS Response to "A Case Study within the Department of Social Services (DSS)"**

Attachments

[Appended to **Part Two: Post-Adoption, 2001-2005**]

Social Security Administration correspondence regarding multiple social security numbers for the CHILD

The Commonwealth of Massachusetts
HOUSE POST AUDIT AND OVERSIGHT BUREAU
ROOM 146, STATE HOUSE
BOSTON 02133-1053

GEOFFREY D. HALL
CHAIRMAN
COMMITTEE ON
POST AUDIT AND OVERSIGHT

JAMES TANSEY
DIRECTOR
(617) 722-2575

7 March 2006

Confidential

Regional Commissioner Manuel J. Vaz
Boston Regional Office
Social Security Administration
Room 1900
JFK Federal Building
Boston, MA 02203

Dear Commissioner Vaz:

I write to you today confidentially regarding multiple social security numbers that appear to be registered to one person who is a subject of a legislative investigation and document review by the House Post Audit and Oversight Committee. I list below four different social security numbers which have appeared on documents which this Bureau is reviewing. These documents attribute the social security numbers to one person, [redacted], a twelve year old girl who was subjected to a vicious physical beating and is today lying in a coma at [redacted] Hospital in Boston. This child is in the care and custody of the Massachusetts Department of Social Services (DSS).

We discovered these differing social security numbers in a document review. As of today, this HPAO Bureau has identified four different social security numbers used for [redacted]. They are:

[redacted] – social security number taken from a Collaborative Assessment Program document; The Collaborative Assessment Program is operated by the Commonwealth of Massachusetts.

[redacted] – listed on DSS intake reports and also on a document from Metro West Medical Center.

[redacted] – listed on a document from Noble Hospital, Westfield, Mass. (11 Sept. 2006 - day of coma/accident)

[redacted] – listed as a MBHP (Mass. Behavioral Health Partnership) number for Westfield Area Mental Health treatment note document. This number has "x" preceding the social security number.

While I am notifying you immediately and offer any further assistance you may need. I also request that you treat this notice confidentially at this time. In addition to the on-going HPAO legislative investigation there is an ongoing criminal investigation against one of the alleged abusers. The policy of the HPAO Committee and its Bureau is to have no comment on an investigation to any media until it is concluded. This Bureau and House Counsel to the Massachusetts House of Representatives have also been in touch with, and is working cooperatively with, [redacted] and [redacted]

Please advise us if we can be of any assistance. I am in the field for the next two or three days but can be reached by phone. Or, if you prefer, please contact Mr. Louis Rizoli, House Counsel to the Massachusetts House of Representatives. My telephone number is 617-722-2575. Mr. Rizoli's telephone number is 617-722-2360.

Thank you for your attention to this matter,

Sincerely yours,

James Tansey

James Tansey
Director

cc: Rep. Geoffrey D. Hall, chairman
Rep. Michael A. Costello, vice chairman
Mr. Louis Rizoli, House Counsel
[redacted]

SOCIAL SECURITY

Regional Office
19th Floor – John F. Kennedy Federal Building
Boston, MA 02203

March 13, 2006

Mr. James Tansey
Director
Post Audit and Oversight Bureau
Room 146, State House
Boston, MA 02133

Dear Mr. Tansey,

I am writing in response to your letter dated March 7, 2006 regarding the possibility that the Social Security Administration (SSA) has issued multiple social security numbers to [redacted].

I can confirm that [redacted], [redacted], [redacted] and [redacted] are invalid Social Security numbers. SSA has not yet issued these numbers to anyone.

Furthermore, SSA's disclosure regulations allow us to verify that [redacted] was assigned to [redacted].

If you have any further questions, please call me. My telephone number is 617-565-[redacted].

Sincerely yours,

Manuel J. Vaz

Manuel J. Vaz
Regional Commissioner

Attachments

[Appended to **Part Two: Post-Adoption, 2001-2005**]

Letter from Local 509, Service Employees International Union regarding CHILD and the previous recommendations from earlier reports regarding the Department of Social Services.

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400 Talcott Avenue
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617-924-8509
FAX 617-924-8248
mail@509SEIU.com
www.SEIU509.org

LOCAL 509
SEIU
Stronger Together

150 Fearing Street
Amherst, MA 01002
413-549-7348
FAX: 413-549-8253

4/28/2006

Geoffrey D. Hall
Chairman
House Committee on Post Audit and Oversight
State House
Boston, Ma 02133

Dear Mr. Chairman:

As a follow up to my previous letter, and as you review the report of the [redacted] Panel, the key issue is that the recommendations are not new. They were in one form or another (with the exception of the end of life decision) contained in the 1993 Governor's Commission Report or the 2001 "Call to action" by Massachusetts Citizens for Children.

The Commission said on page 70 of its report "Current caseloads of DSS staff virtually assure continued substantial risks to children in the care of the Department. So long as that situation persists, any policy managerial or structural amelioratives will be doomed to fail." Yet DSS has in fact focused more on managerial and policy changes rather than address the core issue.

A risk assessment process or new forms will not substitute for the above. Risk assessment, is not a new idea it was addressed in the 1993 Special Commission on Foster Care Report. It is a tool to help make decisions. As such, it is only as good as its design, reliability and the information available about the family. In a hospital setting it does not substitute for a failure to provide a sufficient number of nurses, doctors, technicians and diagnostic equipment. It would be wrong to see it a quick and inexpensive cure for the issues faced by DSS.

I sent a complete copy of the 1993 Commission report with my last letter and the summary of recommendations to all committee members. A few examples from the 1993 report that either mirror or are similar to the recommendations of the [redacted] Panel are:

- Page 118 - Each area office should have an in house team consisting of a pediatrician, psychologist, battered women's and substance abuse specialist and should establish liaisons with the local police and the District Attorney's office. On page 274 the call is repeated for "Multi-disciplinary teams within the agency to give social workers access to medical, psychiatric and psychological consultants..."

- Page 14 - Mental Health diagnostic services are necessary and must be readily accessible to children in the custody of DSS and to post finalization children ...Managed health care systems, as they have developed in the Commonwealth, are a barrier to the effective delivery of mental health services to abused and neglected children...

- Caseloads and the need to reduce them to CWLA levels and adjust for the complexity and level of crisis appear throughout the report. Just one example p36 "Appropriate staffing levels must be established for DSS. At a minimum the levels endorsed by the Child Welfare League of America must be expected, although a system of establishing lower caseload standards for particularly difficult and complex cases must also be devised. Also see page 255.

- P265 - summarized investigation Unit changes. "Investigations of suspected abuse or neglect should be conducted by dual skills teams, with highly trained members. One member of each team would specialize in forensic skills but would be thoroughly familiar with clinical issues. The other member of the team would be expert in clinical assessment but familiar with forensic issues..."see page 132 through 137. DSS is only now getting the Child Welfare institute up and running. DSS still does not require that managers free up social workers for the up to 8 days yearly training referred to in the contract (caseload also is an issue here).

- These are just 2 of many references to the case record system Page 61 In light of the frequent crises in these cases, aggravated by the excessive caseloads, plus frequent transfers of cases, it seems doubtful that a DSS social worker has sufficient time to review files. Narratives, ongoing summaries of events, actions taken and outcomes from a clinical perspective were lacking. Easy access to such information is essential to good case management and clinical practice. Page 29 – Antiquated automated systems which only collect management information and do not directly support or enhance the delivery of services. (Family net is new but suffers from the same management rather than service\casework focus). Family Net also requires more time on the computer as support staff positions were reduced.
- P60 the DSS management information system ...gave confusing guidance to staff and generated mainly management reports, not helpful reports of clinical significance. Instead caseworkers are required to spend valuable time feeding information to management, when the time more appropriately would have been spent on casework. P74 – A management information system for DSS must be established which will guide sound practice and organize information needed for the delivery of services to children and families."

What has been lacking is executive leadership. No Governor since the 1993 Special Commission Report was issued has been willing to heed the now prophetic statement of the

Commission, "The changes that must be made in the child welfare system cannot wait ...To do otherwise would expose too many children to unacceptable risks of severe physical injury and blighted lives".

The [redacted] Panel found that, "The inability to properly assess or challenge clinical opinions and conditions hindered good decision making from the start. ...As DSS became increasingly alarmed for [redacted]'s safety, it was faced with significant opposition on the part of her clinical providers...DSS may or may not have been able to overcome that opposition, but with access to appropriate expertise it could at least have assessed and addressed it." To address this the Panel recommends, "DSS should have on retainer panels of medical professionals in the areas of child abuse, psychiatry ... These professionals should be in a position to respond quickly to inquiries by regional and line workers."

DSS had a few multi-disciplinary teams in 1993. They were called Family Life Centers. The Family Life Centers, which were also supported in a 1992 Senate Post Audit report, met most of the standards recommended by the 1993 Commission on Foster Care. Some restructuring might have been needed but they had a pediatrician, psychologist, and psychiatrist, nurse who would actually see the family and child not just consult. And they provided a significant long term (1year) training experience for social workers assigned to the units. These workers after a year went back to their area offices with new skills.

There are other models. Dr. Charles Welch another member of the Foster Care Commission is aware of these. Again from my perspective it is the issue that the recommendation is long standing (no matter what the actual make up). DSS social workers need access in-house to expert advice from medical personnel and other specialist who can work directly with the families to help sort out complicated issues beyond a social workers training.

Instead of going in that direction the existing Family life Centers were terminated in 1994. DSS also laid off the 12 nurses it had (1994 and again 2002). The nurses at least provided some medical consultation. When they were let go, social workers once again were without any medical support. DSS has not and is not making any attempt to bring them back. Everything falls on the social worker that still is responsible for far too many families and individuals (over 200 family members, doctors, foster parents, probation officers, teachers and others in an average caseload).

A social worker, with a case as intricate and complicated as [redacted]'s, should have a significantly reduced caseload. In DSS that is not an option because of staff shortages.

If Child Welfare League of America (CWLA) staffing standards were in place and funded then that would happen. H3142 sitting in House Ways and Means would do that. H2832 also in Ways and Means would extend the investigation time frame to 15 working days similar to the 20 calendar days the panel recommended. These were both filed by the Union before the panel report and resisted by the administration.

Two final points: If the Multi-disciplinary teams which were in existence and the expansion of which was called for by the 1993 Special Commission on Foster Care had continued to exist. DSS would have had in place a major recommendation of the [redacted] Panel and also would have had hundreds of more highly trained social workers. Might that have changed the outcome in [redacted]'s situation? We will never know. We do know that the failure to have such teams was a direct decision of the agency.

The other issue relates to [redacted] Much of the speculation is around the contractor and the failure to monitor the placement or the skill of the specialized foster parent. This exploration falls short of another key issue. What policies, procedures or managerial decisions resulted in the need for [redacted] to go to the specialized foster home? DSS has policies that say family members are the placement of choice. According to the papers he had lived with relatives for years, I think without 51A's. What policies prevented his placement while issues were resolved? Why did he move from the residential program he was in to the specialized home when DSS intended to move him to relatives soon? Was it in his best interest to put him through another move to adjust to yet more strangers?

The above is not a comprehensive review but sent in hope of providing some highlights. I look forward to meeting with you.

Sincerely,

Edward J. Malloy Jr. Med., MSW, LICSW
Past member of 1993 Governor's Special Commission on Foster Care
President DSS Chapter
SEIU Local 509
Cell 617-[redacted]

Attachments

[Appended to **Part Two: Post-Adoption, 2001-2005**]

Letter regarding "end of life issues" sent to Governor Romney and Speaker DiMasi

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*Also admitted in DC
^Also admitted in FL
^Also admitted in TX

January 24, 2006

By Facsimile 617/727-9725 and Regular Mail
Honorable W. Mitt Romney
Governor - Commonwealth of Mass.
State House - Room 360
Boston, MA 02133

By Facsimile 617/722-2313 and Regular Mail
Honorable Salvatore F. DiMasi
Speaker, Mass. House of Representatives
State House - Room 356
Boston, MA 02133

RE: Special Commission to Investigate DSS

Dear Governor Romney and Speaker DiMasi:

Sometime in October of 2005 I was approached by counsel for [redacted] to handle the appeal of the significant "end of life" issues concerning an order obtained by the DSS for a child in their custody. After reviewing the case file I agreed to handle the case solely on the "end of life" issues. My firm became involved because of what I perceived to be multiple, serious errors made by the Department and the Courts which deprived this child of the opportunity to fight for her life. In order to clearly establish our interest was limited to the end of life issues we have accepted no compensation for our work. As we became more deeply immersed in this case we also understood the secrecy surrounding the government's actions in this matter has exacerbated the poor decision making process and, we believe, has led to a lack of public confidence in the actions of both the Department and the Courts in this case.

First, I want to thank both of you for your constructive response to this tragedy. Establishing reviews independent of the Department is an excellent beginning to try to insure this does not happen again. I also believe your expressed intention to focus on fixing the process and not the blame is the only approach which assures we learn from this experience.

Second, I would ask that your respective committees consider the following legislative and policy changes which our experience has shown need to be addressed:

A. Secrecy/Impoundment. The concurring opinion in the SJC authored by Justice Spina calls for legislative changes so that the public can be cognizant of how government is making these decisions. In the 1970's when Sakiewicz was first decided and the SJC ruled that these decisions ought to be made in the Courts one of the policy arguments was that they were being made behind closed doors in the hospitals by doctors and family. How ironic that now we have a situation where the SJC says the present state of law requires they be made behind closed doors in courthouses by government. That should change immediately, with some allowance to use pseudonyms for privacy purposes. In our situation the Courts would not even let all counsel see medical records, yet the DSS held a press conference and discussed the child's psychiatric problems.

B. Burden of Proof. In 1992 the SJC decided that government's decisions on the withdrawal of medical treatment that will likely or even certainly lead to death need only be established by the "preponderance of evidence" standard. Guardianship of Doe, 413 Mass. 512, 524 (1992). Clearly that standard is too low. This case is evidence of that. Consider that if anyone is charged with inflicting these injuries the government will have to prove that case "beyond a reasonable doubt" but the DSS seeking an order that will end life need only prove its claim by a "fair preponderance of the evidence." The higher standard ought to apply in any case where the remedy sought is likely to lead to the end of a life. It is a fundamental constitutional principle that the burden of proof ought to be commensurate with the interests at stake and no right is more basic than life.

C. Mandatory Stay and Appellate Review. One of the heros in this case is Justice Judith Cowin who imposed a stay on the lower Court's order while she reported the case to the full bench. Without that stay the order would have been implemented and an innocent life lost. In order to get the matter before Justice Cowin a petition for supervisory relief under G.L. c. 211 § 3 had to be prepared and presented to the Court all within an unusually brief window granted by the lower Court.

This case involves the life of an innocent, yet she has been given less protection than is granted to those who commit the most serious crimes. The appellate rights of someone convicted of murder provide for total review of the record below by the SJC. See G.L. 27 § 33E. Yet an innocent whose death is being ordered by a court at the request of the Commonwealth has no comparable rights. Beyond that people in this position have not selected their own attorney or Guardian Ad Litem. Legislation should protect them and require full, complete and mandatory expanded appellate review before their lives are lost.

D. Skills of Counsel and GAL. Continuing with the contrast of rights, properly guaranteed to the accused, yet not provided to the innocent whose very life is sought to be ended, those accused of the most serious crime can only be represented by appointed attorneys with special expertise and training. This case demonstrates the need for a similar requirement in end of life decision making. It is well to remember that as far as the record indicates all other counsel were in agreement with termination of life support even though the doctors were not. There is a need to have legislation specifically set forth the requirement that someone, counsel for the patient or the GAL, must argue for life. Without this requirement there is no adversarial proceeding, no cross-examination, no opposing evidence presented and argued. In effect these cases are being decided collusively without an actual case and controversy.

E. Superior Court. Serious consideration should be given to requiring any government request involving an order seeking medical authorization likely to lead to the end of a life be heard in the Superior Court only. That Court is more experienced dealing with complex cases particularly involving difficult medical issues.

F. Establishment of Legislative Standards. Finally and perhaps most significantly, we need legislation that clearly sets forth what standards will be applied when a Court is making end of life decisions. Judges should not be allowed to impose their own views, particularly when there is no evidence of the wishes of the patient. This occurs when the Courts are dealing with minors and the life long seriously impaired. What are the standards acceptable to the people of this Commonwealth? The legislature and not the Court is the appropriate forum to make that judgment. Should the DSS, itself decide when to seek such an order? Are we better off if it needs permission from another branch of the executive not bound up in their daily duties?

These are merely the most pressing issues brought forth by this sad case. We would be pleased to work with the staff of any of these Committees or appear before them to expand upon what we have learned from these last several months.

Again, thank you both for your interest and leadership on this vital issue.

Very truly yours,

John J. Egan

JJE:dbm

12535-051055\106535.wpd

Attachments

[Appended to **Part Two: Post-Adoption, 2001-2005**]

Care and Protection of Sharlene, Massachusetts Supreme Judicial Court , SJC-09629, December 6, 2005-January 17, 2006

840 N.E.2d 918

Page 1

445 Mass. 756, 840 N.E.2d 918
(Cite as: 445 Mass. 756, 840 N.E.2d 918)

Supreme Judicial Court of Massachusetts,Suffolk.
CARE AND PROTECTION OF SHARLENE.
Argued Dec. 6, 2005.
Decided Jan. 17, 2006.

Background: Stepfather of 11-year-old child filed a petition challenging the denial of his motion to be declared child's de facto parent and to participate in a hearing on a joint emergency motion for an order to withdraw child's life support and not resuscitate. The case was reported, without decision, by a single justice of the Supreme Judicial Court, Suffolk County, Cowin, J.

Holdings: The Supreme Judicial Court, Greaney, J., held that:

1(1) stepfather failed to established that he was child's de facto parent;

3(2) juvenile court judge was entitled to draw a negative inference from stepfather's intention to invoke his right not to testify;

5(3) stepfather had no right to participate in medical decisions affecting the child; and

7(4) juvenile court properly ruled that its findings and order with regard to emergency motion should remain unavailable to the general public.

So ordered.

Spina, J., filed a separate concurring opinion in which Cowin, J., joined.

West Headnotes

[1] Parent and Child 285 ⚿14

285 Parent and Child
285k14 k. Stepchildren. Most Cited Cases
Stepfather of 11-year-old child failed to established that he was child's de facto parent; beyond his unsupported statement that "[h]e felt in his heart that he was her father and she felt that way toward him," stepfather proffered no evidence that would allow a conclusion that his participation in child's life was of a loving or nurturing nature, or even that it was beneficial to the child.

[2] Parent and Child 285 ⚿15

285 Parent and Child
285k15 k. Persons in Loco Parentis. Most Cited Cases
A "de facto parent" resides with the child and, with the consent and encouragement of the legal parent, performs a share of caretaking functions at least as great as the legal parent.

[3] Evidence 157 ⚿76

157 Evidence
157II Presumptions
157k74 Evidence Withheld or Falsified
157k76 k. Failure of Party to Testify or Giving Evasive Answers. Most Cited Cases
Juvenile court judge was entitled to draw a negative inference from stepfather's intention to invoke his right not to testify with respect to his knowledge of the manner in which 11-year-old child's injuries were inflicted, for purposes of determining whether stepfather was child's de facto parent. U.S.C.A. Const.Amend. 5.

[4] Witnesses 410 ⚿293.5

410 Witnesses
410III Examination
410III(D) Privilege of Witness
410k293.5 k. Proceedings to Which

Privilege Applies. Most Cited Cases
The privilege against self-incrimination applicable in criminal proceedings is not applicable to child custody proceedings. U.S.C.A. Const.Amend. 5.

[5] Health 198H 911

198H Health
198HVI Consent of Patient and Substituted Judgment
198Hk911 k. Minors in General; Consent of Parent or Guardian. Most Cited Cases

Parent and Child 285 14

285 Parent and Child
285k14 k. Stepchildren. Most Cited Cases
Since stepfather had no legal or equitable status, as a de facto parent or otherwise, with respect to 11-year-old child, he had no right to participate in medical decisions affecting the child.

[6] Health 198H 915

198H Health
198HVI Consent of Patient and Substituted Judgment
198Hk913 Terminal Illness; Removal of Life Support
198Hk915 k. Substituted Judgment; Role of Courts, Physicians, Guardians, Family or Others. Most Cited Cases
Stepfather of 11-year-old child lacked standing to challenge juvenile court's order to withdraw child's life support and to refrain from resuscitating child, or to challenge the court's findings on the matter; stepfather had no legal or equitable status, as a de facto parent or otherwise, with respect to child.

[7] Infants 211 133

211 Infants
211VIII Dependent, Neglected, and Delinquent Children
211VIII(A) In General
211k133 k. Juvenile Records. Most Cited Cases
Juvenile court properly ruled that its findings and order with regard to an emergency motion filed jointly by the Department of Social Services and 11-year-old child's counsel, requesting an order that the child's health care providers withdraw all life support measures currently in place and make no attempt to resuscitate her on the occurrence of cardiac or respiratory arrest (DNR order), should remain unavailable to the general public. M.G.L.A. c. 119, § 38.

[8] Action 13 13

13 Action
13I Grounds and Conditions Precedent
13k13 k. Persons Entitled to Sue. Most Cited Cases
The essence of standing, as it pertains to a private person, is whether the person has alleged a personal stake in the outcome of a controversy.

****919** John J. Egan & John M. Thompson, Boston (Edward J. McDonough, Jr., Springfield, with them) for the petitioner.
Virginia A. Peel, Boston, for Department of Social Services.
Lisa M. Kling, Springfield, for Sharlene.
Pamela J. Szmyt Hastings, Committee for Public Counsel Services, for the siblings of Sharlene, amici curiae, submitted a brief.

Present: MARSHALL, C.J., GREANEY, IRELAND, SPINA, COWIN, SOSMAN, & CORDY, JJ.
GREANEY, J.
***757** This case is before us on a reservation and report, without decision, by a single justice of this court. The petitioner ****920** is the stepfather of an eleven year old child (whom we shall refer to by the pseudonym Sharlene) who was admitted to Baystate Medical Center (Baystate) on September 11, 2005, with critical injuries. As a result of her injuries, Sharlene remains in an irreversible vegetative state. On September 13, the Department of Social Services (department) filed a care and protection petition, pursuant to G.L. c. 119, § 24, and received custody of Sharlene. Counsel and a guardian ad litem (GAL) were appointed for Sharlene. On September 22, Sharlene's adoptive mother, and only legal guardian, died. On September 26, a judge in

the Juvenile Court denied a motion filed by the petitioner (who has been criminally charged with assault and battery on Sharlene [FN1]) to be declared the child's de facto parent. On October 5, after a closed evidentiary hearing, which the petitioner's counsel attended, but in which he was not allowed to participate, a judge allowed an emergency motion filed jointly by the department and Sharlene's counsel (joint emergency motion), requesting an order that the child's health care providers withdraw all life support measures currently in place and make no attempt to resuscitate her on the occurrence of cardiac or respiratory arrest (DNR order). The judge further ordered that his written decision allowing the joint emergency motion be impounded and released only to the department, Baystate, Sharlene's counsel, and Sharlene's GAL. The petitioner challenged the impoundment order and, after an evidentiary hearing on October 17, the judge modified that order to provide that his decision be made available only to persons connected with the case, including the petitioner, but not to the general public.

FN1. The petitioner asserts that the criminal case pending against him is in connection with injuries that were inflicted on Sharlene sometime prior to the injuries that have hospitalized her in her present condition.

In a petition filed pursuant to G.L. c. 211, § 3, the petitioner challenges the denial of his motion for de facto parental status ***758** and seeks a new hearing on the joint emergency motion, in which he, as Sharlene's de facto parent, has a voice. He also argues that the public should be allowed access to all proceedings (except for a new hearing, should one be ordered by this court) and all relevant documents in this case. We have carefully examined the record and the GAL report (which we requested and received from the Juvenile Court) and have ordered and listened to recordings of the hearings that took place. For reasons stated in this opinion, we affirm the denial of the petitioner's motion to be declared Sharlene's de facto parent and conclude that the petitioner properly was excluded from participation in the hearing on the emergency joint motion. As to the public access issue raised in the petition, we seriously question whether someone in the petitioner's position has standing to assert such a claim on behalf of the public. We nevertheless consider, and reject, the claim and affirm the judge's order that the documents relevant to this case should not be used for further publication without a specific order by the judge. We also have before us the order to withdraw life support currently in place for Sharlene and to refrain from resuscitation. We affirm that order as well.

We will begin by summarizing the relevant facts of Sharlene's life. We then will describe, in some detail, the procedural history of this case. Finally, we will address the substantive issues raised by the petition.

Sharlene was born on February 24, 1994. Her biological mother was sixteen years old and not married to Sharlene's ****921** biological father. [FN2] When Sharlene was four years of age, she was sent to live with her aunt (who would later become her adoptive mother). That same year, based on a determination that Sharlene had been sexually abused by her biological mother's boy friend, the department sought and received custody of Sharlene, but allowed Sharlene to remain in her aunt's home as a foster child. The petitioner began living in the home in February, 2000, and married Sharlene's aunt in September, 2001. In October, 2001, Sharlene was adopted by her aunt (hereinafter, adoptive mother) as a single parent.

FN2. The biological father has been absent from Sharlene's life and has no role in this case.

***759** The GAL report, which was submitted to the judge in connection with the joint emergency motion, contains a considerable amount of information dealing with developmental and social difficulties with which Sharlene struggled throughout her young life. This information appears to have been gathered from the department's reports, the authenticity of which was never established. We therefore omit the

information for purposes of this opinion. The GAL report did disclose that multiple reports have been filed with the department, pursuant to G.L. c. 119, § 51A, involving Sharlene and her two siblings,[FN3] since January, 2001. The GAL report set forth the following chronological history of child abuse reports and investigations involving Sharlene alone:

> FN3. Sharlene's siblings, who are nine and two years of age, are the biological children of Sharlene's adoptive mother. The younger child is the biological child of the petitioner.

"9/27/02 Child Abuse/Neglect Report. Allegations of neglect and physical abuse of [Sharlene] Screened Out.[FN4]

> FN4. The department "screens" allegations of abuse or neglect contained in reports under G.L. c. 119, § 51A. To "screen [in]" means to identify children at risk of abuse or neglect by a caretaker, and to distinguish the need for a nonemergency or emergency response. 110 Code Mass. Regs. § 4.21 (2000). To "screen out" means to determine that the allegations of abuse or neglect by a caretaker contained in the report are unsubstantiated.

"10/24/02 Child Abuse/Neglect Report. Screened in for allegations of neglect and physical abuse of [Sharlene]. Reporter saw bruises on child, concerns about how child is disciplined and child out of school for eight days.
"10/25/02 Child Abuse/Neglect Investigation. Unsupported [FN5] with no reasonable cause to believe that a condition of neglect or physical abuse exists.

> FN5. To "[s]upport" means to find after an investigation that there is reasonable cause to believe a report that a child has suffered abuse or neglect inflicted by a caretaker. 110 Code Mass. Regs. § 2.00 (1996).

"1/6/03 Child Abuse/Neglect Report. Initially screened in for neglect because mother is unable to keep child safe from harm then screened out as [care and protection] referral made.
"12/30/03 Child Abuse/Neglect Report.
***760** "1/13/04 Child Abuse/Neglect Report. Allegations of neglect screened out.
"2/23/04 Child Abuse Neglect Report. Screened in on allegations of neglect. 10 year old [Sharlene] missing for two hours and finally located in bathroom at Noble Hospital which is not close to her home.
"2/23/04 Child Abuse/Neglect Investigation. Unsupported. Child did run away from home but mother acted appropriately.
"6/11/04 Child Abuse/Neglect Report. Screened in because [Sharlene] ****922** had bruises, not in school and does not look as well cared for as other children in the home.
"6/14/04 Child Abuse/Neglect Investigation. Allegations of physical abuse and neglect unsupported. [Sharlene] reports that she bruised her face diving into a pool. Mother responsive to [Sharlene's] self-abusive behaviors by bringing her to pediatrician and following counselor's recommendations.
"6/18/04 Child Abuse/Neglect Report. Screened in for neglect initially and then screened out. Mother addressing issues with child's therapist, mother agreed to voluntary services, child hospitalized and mother working with therapist to get child placed in residential care.
"6/25/04 Child Abuse/Neglect Report. Mother's application for voluntary services accepted.
"7/15/04 Child Abuse/Neglect Report. Screened in for physical abuse and neglect of [Sharlene] by her mother. [Sharlene] has bruises on arm.
"7/15/04 Child Abuse/Neglect Investigation. Supported for neglect, mother inadequately supervised [Sharlene] in store despite prior history of [Sharlene] stealing in a store.
"7/16/04 Child Abuse/Neglect Report. Screened in. Case currently open for voluntary services and investigation.
"8/18/04 Child Abuse/Neglect Report. Screened in for ***761** neglect. Child received burns during a bath then screened out because department is currently involved with family and closely monitoring [Sharlene's] care.

"1/14/05 Child Abuse/Neglect Report. Screened out.
"4/14/05 Child Abuse/Neglect Report. Screened in due to concerns about the level of supervision provided for [Sharlene] given the extent of her injuries in light of her history.
"4/14/05 Child Abuse/Neglect Investigation. Allegations of Neglect unsupported.
"5/11/05 Child Abuse/Neglect Report. Screened in due to allegations of neglect. Mother did not seek medical attention when [Sharlene] complained of a headache and was vomiting. Mother left [Sharlene] alone at softball game and she was hit in the head with a baseball bat.
"5/11/05 Child Abuse/Neglect Report. Allegation of neglect unsupported. Incident was an accident. Adequate services in place to assist with monitoring.
"9/11/05 Child Abuse/Neglect Report. Screened in for abuse by unknown perpetrator based upon the child's multiple bruises and fractures in different stages of healing.
"9/12/05 Child Abuse/Neglect Investigation. Supported. Reasonable cause to believe that a condition of physical abuse and neglect exists. [Sharlene] sustained serious life threatening injuries which were the result of trauma." [FN6]

FN6. In spite of receiving a total of fifteen G.L. c. 119, § 51A, reports over a period of three years, all alleging that Sharlene was an abused or neglected child, it was not until the last report was filed that allegations of abuse were determined to be supported. That determination came too late to protect Sharlene.

The final allegation of child abuse was filed on behalf of Sharlene on September 11, 2005. On that day, Sharlene was brought in a comatose state to a hospital in Westfield with multiple bruises all over her body in different stages of healing, "crusted areas" on her chest, a fractured nose, and multiple old fractures, also all over her body. She was transported to ****923** nearby ***762** Baystate, and there was diagnosed with a severe traumatic brain injury, manifested clinically by fixed and dilated pupils, complete unresponsiveness, and a body temperature of eighty-five degrees. A CT scan of Sharlene's brain revealed a right-sided subdural hematoma and a magnetic resonance image (MRI) revealed hemorrhagic contusion of the brain stem and shear injury of the brain, including the corpos callosum (high force injury). Sharlene was intubated and placed on a respirator for breathing and a feeding tube was inserted into her nose. She has been in a vegetative state and on life support since that time. It was the opinion of one of Sharlene's physicians that her injuries could not have been self-inflicted.

On September 13, the department named the petitioner and Sharlene's adoptive mother in the care and protection petition referred to above,[FN7] and, as has been stated, counsel for Sharlene and a GAL were appointed. The department received temporary custody of Sharlene at that time. See G.L. c. 119, § 24. On September 19, the department and Sharlene's counsel filed the joint emergency motion requesting the DNR order that has been described above. The joint emergency motion also requested the judge to expand the role of Sharlene's GAL to focus on evaluating whether the requested DNR order should issue.

FN7. Sharlene's siblings were also subjects of the petition and remain parties to the ongoing care and protection proceeding. Their counsel has been involved, to some degree, in the proceedings leading up to this case, including attending the hearing on the joint emergency motion, and filing a petition to this court, pursuant to G.L. c. 211, § 3, seeking access to the judge's written decision regarding his order allowing that motion.
The siblings are not, however, parties to this case. Their counsel has filed an amicus brief on their behalf to present their point of view on the impoundment issue.
In their brief, the siblings assert that the judge properly ordered that the general public be excluded from the proceedings arising out of the joint emergency motion.

Sharlene's adoptive mother and the petitioner were

arraigned in the Westfield Division of the District Court Department on charges relating to injuries that Sharlene allegedly sustained at their hands. The mother was released on bail on September 22, and died later that day, apparently, as the result of a murder-suicide or double suicide.[FN8]

> FN8. From newspaper accounts, it appears that the mother's body and that of the mother's grandmother were discovered at the same time.

On September 26, the petitioner filed a motion requesting to ***763** be declared Sharlene's "de facto " parent.[FN9] That day, the judge held a hearing on the motion at which he considered the arguments of the petitioner and the department. Through counsel, the petitioner described his relationship with Sharlene during the four years in which he had lived in the home. The petitioner proffered that he had supported her financially, had attended her dance recitals, had taught her how to perform minor repair jobs around the house, and generally took an interest in her welfare. He stated that Sharlene had no other father figure during the four years he lived in the house, and pointed out that, to her friends, Sharlene referred to him as "her father, her dad." The petitioner conceded that he did not perform a majority of Sharlene's parenting functions, but insisted, essentially, that he did the best that he could. When questioned by the judge ****924** as to whether he would testify to his knowledge of Sharlene's injuries and the manner in which they were inflicted, the petitioner informed the judge that he would assert his privilege against self-incrimination under the Fifth Amendment to the United States Constitution.

> FN9. The petitioner also requested in the motion to be declared the "de facto" parent of Sharlene's nine year old sister. The judge denied the motion as to both children. The petitioner has appealed from the denial of his motion only insofar as it pertains to Sharlene.

In opposition to the petitioner's motion, the department argued that, in the four years that the petitioner had lived in the home, the department had interviewed him only once as part of a home visit, because he was not "available." Sharlene's counsel further attested that, by his own statements to police, when the petitioner left home in the afternoon of September 10 (the day before Sharlene was brought to the hospital), he was aware that the child had been injured and was throwing up. He, nonetheless, told the police that he took no steps to check on Sharlene's condition until the following afternoon. Sharlene's counsel argued to the judge, " [T]hat is not a parent, under any circumstances." She also pointed out that Sharlene had old, as well as recent, severe injuries that occurred while the petitioner lived in the house, and "throughout that time, [the petitioner] had to be aware of those and had to have some knowledge of what was going on in the house. And if in fact he was acting as ***764** a de facto parent, he was either participating in the infliction of those injuries or totally ignoring the fact."

The judge concluded that, based on the good faith offers of proof before him, the petitioner had not demonstrated that he is Sharlene's de facto parent.[FN10] Crediting all of the petitioner's proffered evidence, the judge found that the petitioner did not provide a majority of the caretaking functions of the child. The judge drew a negative inference from the petitioner's assertion that he would not testify at an evidentiary hearing as to Sharlene's injuries. The judge further concluded that, because the petitioner is not the legal, adoptive, putative, or de facto father of Sharlene, he would not be allowed to participate as a party in the hearing on the joint emergency motion. As a "courtesy" the judge stated he would allow the petitioner's counsel, and counsel for Sharlene's siblings, to be present at the hearing but not to participate.

> FN10. The written findings of fact on the judge's decision are contained in subsequent written findings of fact entered after the October 5 hearing on the joint emergency motion and the October 17 hearing on the petitioner's challenge to the impoundment issue. The substance of the

two written findings is the same.

On September 30, an evidentiary hearing took place at Baystate in which the judge considered the joint emergency motion requesting a DNR order for Sharlene.[FN11] The judge heard testimony from two of Sharlene's physicians at Baystate, one of Sharlene's nurses at Baystate, Sharlene's department social worker, and Sharlene's GAL. He also considered Sharlene's medical record from Baystate and a report filed that day by her GAL, which documented background information on Sharlene's life, but focused primarily on what should be done for Sharlene at this time.[FN12] As has been indicated, the petitioner's counsel was allowed to attend, but not participate in, this hearing.

FN11. The motion considered was a supplemental motion, filed jointly that day by the department and Sharlene's counsel that did not alter the substance of the original motion but contained additional facts and legal arguments.

FN12. The GAL report concluded, " [Sharlene's] life as she knew it, for better or worse, is over and can never be recovered. While the choice to withhold artificial ventilation, medication, fluid and nutrition is not an easy one that can be made lightly, it is the only decision that will afford [Sharlene] the chance to die quickly and with dignity."

****925** One physician, the director of Baystate's pediatric intensive ***765** care unit (PICU), testified that Sharlene suffered from a "shear" injury to her brain stem that caused a disruption of nerve fibers in that portion of her brain and resulted in irreparable brain damage. He testified that, after Sharlene's admission to Baystate, her intracranial pressure increased due to a stroke of the entire right side, and most of the left side, of her brain. He further testified that Sharlene is in an irreversible coma. The physician explained that, when an injury occurs to the upper brain there are other parts of the upper brain that may be able to take over the function in time. With an injury to a brain stem, however, there is no chance of recovering cognitive or sensate functioning. The physician testified that, "short of developing the technique for a complete brain transplant, there is no hope that medical treatment will be discovered in the foreseeable future which could reverse [Sharlene's] condition." Sharlene's treating physician, the associate director of Baystate's PICU, testified that Sharlene's brain is operating at a primitive level, and that the child cannot see, hear, feel, or respond.[FN13]

FN13. The physician testified that Sharlene cannot make any purposeful movements but, occasionally, will make a " base" movement in response to being touched.

Both physicians supported the issuance of an order that Sharlene not be resuscitated on the occurrence of cardiac or respiratory failure. With respect to the withdrawal of her life support, however, their opinions differed. Sharlene's treating physician recommended both the removal of the ventilator and her feeding tube. The director of the PICU, on the other hand, recommended removal of the ventilator only and expressed opposition to the removal of her feeding tube. The physicians agreed that, with the feeding tube, Sharlene's death would likely occur anytime from several weeks up to two months. Without the feeding tube, Sharlene's death would likely occur in a substantially shorter period of time. The director of the PICU testified that the removal of life support in this case would not be contrary to prevailing medical ethics.

On October 5, the judge entered a written decision, in which he made findings of fact and concluded that "[Sharlene's] dignity and quality of life would be most respected by withdrawing both the ventilator and the feeding tube along with the issuance***766** of a[DNR] order, with great sadness I so issue this day." The judge also ordered that his written decision not be released to anyone except Sharlene's counsel, her GAL, the department, and Baystate.

The petitioner filed a petition for relief pursuant to

G.L. c. 211, § 3, seeking access to the impounded decision. In response to an order of a single justice of this court, the judge held an evidentiary hearing, on October 17, concerning his impoundment order. At the hearing, the petitioner argued that the order should be vacated in its entirety and that all of the proceedings and court records concerning Sharlene be opened to the general public. The judge decided to modify the order to permit counsel for the petitioner to view the October 5, 2005, findings of fact, conclusions of law, and order allowing the DNR and withdrawal of life support. The department and Sharlene's counsel assented to the judge's proposal, and the order was so modified. The judge made written findings of fact and conclusions of law regarding the modification of his October 5 impoundment order and ordered that the petitioner be provided a copy of his written findings and order allowing the joint motion for a DNR and withdrawal of support order. The judge made clear, however, ****926** that the written decision was "not to be used for further publication without specific order of this court."

[1][2] 1. We address first the petitioner's assertion that he is Sharlene's "de facto" parent. This court expressly adopted the concept of "de facto" parenthood in *E.N.O. v. L.M.M.*, 429 Mass. 824, 711 N.E.2d 886, cert. denied, 528 U.S. 1005, 120 S.Ct. 500, 145 L.Ed.2d 386 (1999). In that case, we defined a "de facto parent" as "one who has no biological relation to the child, but has participated in the child's life as a member of the child's family. The de facto parent resides with the child and, with the consent and encouragement of the legal parent, performs a share of caretaking functions at least as great as the legal parent." *Id.* at 829, 711 N.E.2d 886, citing *Youmans v. Ramos*, 429 Mass. 774, 776 & n. 3, 711 N.E.2d 165 (1999), and ALI Principles of the Law of Family Dissolution § 2.03(1)(b) (Tent. Draft No. 3 Part 1 1998). In *Blixt v. Blixt*, 437 Mass. 649, 774 N.E.2d 1052 (2002), cert. denied, 537 U.S. 1189, 123 S.Ct. 1259, 154 L.Ed.2d 1022 (2003), we noted (without adopting) further refinements to the concept-that a de facto parent must live with the child for not less than two years and that the caretaking***767** relationship have been established "for reasons primarily other than financial compensation, and with the agreement of a legal parent to form a parent-child relationship, or as a result of a complete failure or inability of any legal parent to perform caretaking functions." *Id.* at 659 n. 15, 774 N.E.2d 1052, quoting ALI Principles of the Law of Family Dissolution § 2.03(c) (Tent. Draft No. 4 2000).

Our cases, and those of the Appeals Court, addressing the concept have focused exclusively on the existence of a significant preexisting relationship that would allow an inference, when evaluating a child's best interests, that measurable harm would befall the child on the disruption of that relationship. See, e.g., *T.F. v. B.L.*, 442 Mass. 522, 533, 813 N.E.2d 1244 (2004); *Blixt v. Blixt, supra* at 659, 774 N.E.2d 1052; *E.N.O. v. L.M.M., supra; Youmans v. Ramos, supra; Dearborn v. Deausault*, 61 Mass.App.Ct. 234, 238, 808 N.E.2d 1253 (2004) ; *Sayre v. Aisner*, 51 Mass.App.Ct. 794, 800-801, 748 N.E.2d 1013 (2001). See also *Eccleston v. Bankosky*, 438 Mass. 428, 439 n. 17, 780 N.E.2d 1266 (2003) (declining to consider whether "de facto" parent may be held financially responsible for child). The standard established by these cases presumes that the bond between a child and a de facto parent will be, above all, loving and nurturing.

[3][4] We agree with the judge that the petitioner has not established that he is Sharlene's de facto parent. Beyond his unsupported statement in his brief that "[h]e felt in his heart that he was her father and she felt that way toward him," the petitioner has proffered no evidence that would allow a conclusion that his participation in Sharlene's life was of a loving or nurturing nature, or even that it was beneficial to the child. See *C.O. v. M.M.*, 442 Mass. 648, 654-656, 815 N.E.2d 582 (2004) (in civil adversary proceedings, burden on moving party to establish facts by preponderance of evidence). We reject the petitioner's claim that the judge erred in drawing a negative inference from the petitioner's intention to invoke his right not to testify with respect to his knowledge of the manner in which Sharlene's injuries were inflicted. The judge acted well within his authority in drawing the inference. The privilege against self-incrimination applicable in criminal proceedings is not applicable to child custody proceedings. See *Custody of Two Minors*, 396 Mass. 610, 616, 487 N.E.2d 1358

(1986). See also ****927*768***Shafnacker v. Raymond James & Assocs.*, 425 Mass. 724, 735, 683 N.E.2d 662 (1997). The petitioner suggests in his brief that any criminal charges that may be pending against him "are not relevant to the de facto parent issue, but to whether he was a fit parent." This bald assertion utterly misapprehends the concept of de facto parenthood. The petitioner stands charged with criminal assault in connection with injuries inflicted on Sharlene. See note 1, *supra*. To recognize the petitioner as a de facto parent, in order that he may participate in a medical end-of-life decision for the child, is unthinkable in the circumstances of this case and would amount to an illogical and unprincipled perversion of the doctrine.

[5] 2. Because the petitioner has no legal or equitable status, as a de facto parent or otherwise, with respect to Sharlene, he has no right to participate in medical decisions affecting the child. Such decisions are within the scope of the custodial powers of the department. See G.L. c. 119, § 21. [FN14] See also *Care & Protection of Jeremy*, 419 Mass. 616, 620 n. 7, 646 N.E.2d 1029 (1995). For decisions involving extraordinary medical care of a child in its custody, such as an order to give or withhold life-prolonging treatment, the policy of the department is to seek prior judicial approval and, in addition, the appointment of a GAL to investigate whether an order for such treatment should enter. See 110 Code Mass. Regs. §§ 11.13, 11.17 (1993); 110 Code Mass. Regs. § 11.18 (1995). At the request of the department and Sharlene's counsel, the judge conducted an evidentiary hearing to make a "substituted judgment" determination on the merits of the joint emergency motion and requested order that would permit Sharlene's medical providers to withdraw her life support and to refrain from resuscitating her. See *Care & Protection of Beth*, 412 Mass. 188, 194-195, 587 N.E.2d 1377 (1992); *Superintendent of Belchertown State Sch. v. Saikewicz*, 373 Mass. 728, 738-739, 370 N.E.2d 417 (1977). In these circumstances, such a judicial determination is appropriate. See *Matter of Moe*, 385 Mass. 555, 565, 432 N.E.2d 712 (1982), quoting *Superintendent of Belchertown State Sch. v. Saikewicz*, *supra* at 752, 370 N.E.2d 417 ("the court dons 'the mental mantle of the ***769** incompetent' and substitutes itself as nearly as possible for the individual in the decision-making process.... [T]he court does not decide what is necessarily the best decision but rather what decision would be made by the incompetent person if he or she were competent"); *Guardianship of Roe*, 383 Mass. 415, 444, 421 N.E.2d 40 (1981) (judge should consider [1] patient's expressed preferences, if any; [2] patient's religious convictions, if any; [3] impact on patient's family; [4] probability of adverse side effects from treatment; and [5] prognosis with and without treatment). See also *Norwood Hosp. v. Munoz*, 409 Mass. 116, 125, 564 N.E.2d 1017 (1991) (judge also should consider countervailing State interests, including preservation of life, protection of innocent third parties, and maintenance of ethical integrity of medical profession). At the hearing, the judge applied the "substituted judgment" standard and properly considered as well the traditional "best interests of the child" test. See *Care & Protection of Beth*, *supra* at 195 n. 11, 587 N.E.2d 1377 (noting that substituted judgment doctrine consistent with "best interests of the child" test); ****928***Custody of a Minor (No. 1)*, 385 Mass. 697, 710, 434 N.E.2d 601 n. 10 (1982), quoting *Custody of a Minor*, 375 Mass. 733, 753, 379 N.E.2d 1053 (1978).

> FN14. At the time that the department and Sharlene's counsel filed the joint emergency motion, Sharlene was in the department's temporary custody. See G.L. c. 119, § 24. At the time of the hearing on the motion, Sharlene was (and continues to be) in the permanent custody of the department. See G.L. c. 119, § 26.

The judge carefully considered the factors required by our cases, set forth above, under the settled preponderance of the evidence standard. See *Guardianship of Doe*, 411 Mass. 512, 523-525, 583 N.E.2d 1263, cert. denied sub nom. *Doe v. Gross*, 503 U.S. 950, 112 S.Ct. 1512, 117 L.Ed.2d 649 (1992). We summarize his determinations.[FN15] The proposed order was requested in good faith and not for "administrative convenience." Sharlene is unable to express any preference regarding the requested order. Sharlene is Catholic, although

there was no evidence that she, or her family, actively practiced that faith or that Sharlene held any religious beliefs or convictions that would preclude the requested order. Sharlene's legal mother is deceased, and the rights of her biological parents had been terminated. Sharlene's biological mother and maternal grandmother both support Sharlene's removal from life support. Sharlene is in an irreversible and permanent coma, with the least amount of brain function that a person can have and still ***770** be considered alive. She is not aware of her surroundings and does not experience pain or discomfort. The judge concluded that if Sharlene could rationally consider her current medical condition, and her future prognosis, she would accept the joint request of the department and her counsel to enter the order.

FN15. As a preliminary matter, the judge found Sharlene to be incompetent. No one questions this determination.

[6] The petitioner has no standing to challenge the judge's findings on this matter or his order to withdraw life support or to refrain from resuscitating the child. The order is the product of careful consideration by an experienced judge who heard from all interested parties, who received a comprehensive and thoughtful GAL report, and who entered specific findings on the appropriate factors he considered. See *Guardianship of Doe*, *supra* at 524, 583 N.E.2d 1263.[FN16] Counsel for Sharlene did not oppose the order, nor did Sharlene's existing family members. The medical evidence is incontrovertible-the child is in a persistent vegetative state and there is no medical treatment in the foreseeable future that can restore her cognitive abilities. No provision of medical ethics is violated by the order. As the GAL report notes: "To all extent and purpose [Sharlene] has already left this world consciously****929** and subconsciously and the only real remaining question is under what circumstances she'll be allowed to leave it physically."

FN16. As has been discussed above, the judge applied the "substituted judgment" standard and "best interest of the child" test as set forth in *Care & Protection of Beth*, 412 Mass. 188, 194-195 & n. 11, 587 N.E.2d 1377 (1992). The " substituted judgment" standard is somewhat awkward in a case like this involving a young child who is not old or mature enough to have expressed her wishes on some of the factors. It might be argued that a matter of withdrawal of medical treatment in such a case is more properly left to a decision by the treating physicians, in consultation with such family as the child may have, and consideration of the provisions of medical ethics, under the standards set forth in *Matter of Dinnerstein*, 6 Mass.App.Ct. 466, 475, 380 N.E.2d 134 (1978). In circumstances such as here, however, where a child in the department's custody cannot speak for herself and no interested party opposes the order, an objective evaluation of the child's "best interests," with special emphasis on the quality of the child's life, see *Yannas v. Frondistou-Yannas*, 395 Mass. 704, 711, 481 N.E.2d 1153 (1985), and any other factors pertinent to the child, provides critical guidance for a judge charged with the ultimate end of life decision. Here, the child's biological mother, her grandmother, and her two siblings do not oppose the order and have not come forward with any information that would allow an inference that life support to maintain Sharlene's irreversible comatose condition would be in her best interests.

[7] 3. We now turn to the petitioner's challenge to the impoundmentorder, ***771** a challenge that is based, as far as we can tell, on the proposition that " end of life" issues involving the courts should be resolved in the full light of public disclosure. According to the petitioner, "[t]he public ought to be in a position to judge whether the [department] succeeded or failed in its supervision of this family."

The petitioner requests that this court vacate the impoundment order entered by the judge and enter a new order requiring that all the proceedings in this

case (except the actual hearings) be open to the public and that all documents relevant to this case be accessible by the public.

[8] As a preliminary matter, we find the standing of the petitioner to assert the rights of the general public in this case to be highly questionable. The essence of standing, as it pertains to a private person, is whether the person has alleged a personal stake in the outcome of a controversy. See *Arlington Heights v. Metropolitan Hous. Dev. Corp.*, 429 U.S. 252, 261, 97 S.Ct. 555, 50 L.Ed.2d 450 (1977); *Ginther v. Commissioner of Ins.*, 427 Mass. 319, 323, 693 N.E.2d 153 (1998). As has been made clear in this opinion, his status as a party to the care and protection petition does not entitle him to any special status with respect to Sharlene or court records relating to her medical care. The petitioner is not a member of the general public in the context of this case, but one who has been criminally charged with inflicting injuries on Sharlene. Further, the issue is not as the petitioner states it-whether the department has succeeded or failed in its relationship with Sharlene. Rather, the issue involves the propriety of an order to withdraw medical treatment. In an abundance of caution, we shall nevertheless consider the merits of the impoundment order.

The Legislature has expressly directed that all care and protection proceedings be closed to the public. See G.L. c. 119, § 38 ("All hearings under [§§ 1-37], inclusive, shall be closed to the general public and it shall be unlawful to publish the names of persons before the court in any hearing provided for therein ..."). Consistent with this directive, the Juvenile Court issued a standing order that Juvenile Court "case records and reports are confidential and are the property of the court. Reports loaned to or copied for attorneys of record, or such other persons as the court may permit, shall be returned to the court after their use or at the conclusion of the litigation, whichever occurs first. ***772** Said reports shall not be further copied or released without permission of the court." Juvenile Court Standing Order 1-84. The authority of the Juvenile Court to promulgate standing orders, pertinent to the practice and procedure for conducting the business of the court, is derived from G.L. c. 218, § 60, which makes such orders effective "subject to the approval of the supreme judicial court."

Standing Order 1-84 was approved by this court and adopted on May 8, 1984. This order, which unambiguously makes all Juvenile Court case records the property of the court, makes sense. If the hearings are closed, pursuant to G.L. c. 119, § 38 , in order to protect the confidentiality of the parties, yet the relevant documents remain unsealed, there is no way to protect the confidentiality of the parties, the purpose for which the statute was designed. By maintaining confidentiality the ****930** privacy of Sharlene is safeguarded [FN17] and, importantly, the privacy, both present and future, of her two siblings is protected from public intrusion, so that they may grow and become adults without unnecessary stigma associated with this case. As counsel for Sharlene's siblings notes, "After the media circus surrounding the plight of this child subsides ... her siblings will be left to endure the pain of its aftermath. All three of these children are entitled to the protection [of confidentiality ordered by the] court," as required by statute and rule.

> FN17. The petitioner asserts in his brief that "the child's grave condition, as a practical matter, leaves her unable to comprehend any invasion of privacy and obviates any need to protect her privacy." This statement is disturbing and has no merit. Our laws afford incompetent persons, including children such as Sharlene, equal respect for personal dignity and privacy as competent persons. See *Care & Protection of Beth, supra* at 196-197, 587 N.E.2d 1377, and cases cited.

Because the law governing care and protection proceedings makes those proceedings closed to the public, the Uniform Rules on Impoundment Procedure have no general application to this case. See Rule 1 of the Uniform Rules on Impoundment Procedure (2005).[FN18] We do not depart from our cases that recognize a common-law right of access to the records of ***773** judicial proceedings, see *Boston Herald, Inc. v. Sharpe*, 432 Mass. 593, 605,

737 N.E.2d 859 (2000); *Commonwealth v. Blondin*, 324 Mass. 564, 569, 87 N.E.2d 455 (1949), cert. denied, 339 U.S. 984, 70 S.Ct. 1004, 94 L.Ed. 1387 (1950); *Cowley v. Pulsifer*, 137 Mass. 392, 394 (1884), nor disagree with a decision of the United States Court of Appeals for the First Circuit, cited by the petitioner, holding that the First Amendment to the United States Constitution may encompass a public right of access to records submitted in connection with criminal cases. See *Globe Newspaper Co. v. Pokaski*, 868 F.2d 497 (1st Cir.1989). These decisions, however, did not involve Juvenile Court records, which, by law, are confidential. We conclude that the judge properly ruled that the findings and order of the October 5 hearing should remain unavailable to the general public.

> FN18. In order to seek relief from Standing Order 1-84, the petitioner would have had to file a motion, supported by an affidavit, pursuant to Rule 11 of the Uniform Rules on Impoundment Procedure (2005), which applies to cases where material is required to be impounded by statute, court rule, or standing order. The judge's modification of the original impoundment order, accompanied by written findings, which allowed the petitioner access to the judge's written decision on the joint emergency motion, effected the type of relief contemplated by rule 11.

4. A few final observations are in order. Some describe this as a case about death. It should more correctly be described as a case about a young girl who has suffered tremendously from acts of violence and cruelty and who now will be permitted to pass away with dignity. Sharlene's memory will remind us, time and again, that we, as a society, need to do more to aid children who are neglected and abused, and thereby denied the care and nurturing they so desperately want and need. If Sharlene's case helps other children to escape their misery, her short life will not have been in vain.

5. The order denying the petitioner's motion to be declared Sharlene's de facto parent and to participate in the hearing on the joint emergency motion for an order to withdraw life support and not resuscitate is affirmed. The orders to withdraw life support currently in place for Sharlene and to refrain from resuscitation of Sharlene, and that the documents and records ****931** be released to no one, except by order of the court, are affirmed.

So ordered.

SPINA, J. (concurring, with whom Cowin, J., joins).

I agree with the court's opinion. I write separately to call attention to ***774** an issue that was not raised by the parties but has a significant impact on the public interest. The issue is whether a judicial hearing on a petition to withdraw life support systems from a child should be closed to the public simply because it takes place in the context of a care and protection proceeding.

The Supreme Judicial Court Guidelines on the Public's Right of Access to Judicial Proceedings and Records (2000) begins with the following two sentences: "Judicial proceedings should not be shrouded in secrecy. Access fosters informed public discussion of governmental affairs." The guidelines then quote *Cowley v. Pulsifer*, 137 Mass. 392, 394 (1884) (Holmes, J.), where the court said, " It is desirable that the trial of causes should take place under the public eye, not because the controversies of one citizen with another are of public concern, but because it is of the highest moment that those who administer justice should always act under the sense of public responsibility, and that every citizen should be able to satisfy himself with his own eyes as to the mode in which a public duty is performed." This principle is especially apt in cases that will result, irreversibly, in a loss of life.

Care and protection cases are closed to the public. G.L. c. 119, § 38. The State has a legitimate interest in protecting children from the stigma that may be associated with having parents who are accused of being unfit, or who have been found to be unfit. Orders in care and protection proceedings address these issues "to insure the rights of any child to sound health and normal physical, mental, spiritual and moral development." G.L. c. 119, § 1,

first par. Closed proceedings thus are justified.

The decision to withdraw life support, however, is unlike any other that may be made in a care and protection case. It focuses not only on the child's health and the best interests of the child, but on whether under the substituted judgment standard the child would, if competent, choose to forgo the use of extraordinary means to sustain life. *Custody of a Minor (No. 1)*, 385 Mass. 697, 703, 434 N.E.2d 601 (1982). This standard is the same standard that is applied in every case involving the issue of withdrawal of life support, regardless of the court or the age of the person who is subject to the withdrawal order. *Superintendent of Belchertown State Sch. v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977). The hearing ***775** does not implicate the public policy concerns that provide the basis for closing care and protection cases to the public because it involves no accusation of parental unfitness, remediation of parental unfitness, or stigma associated with parental unfitness that the child will carry with her through life. If the order to withdraw life support is made, it is expected that the child will not live to suffer any stigma.

More important is the need for assurance that those seeking to terminate life in fact have the best interests of the child at heart and that the child's best interests are being served. The public is entitled to know that those seeking the orders are not trying to conceal foul play, or that the expense of maintaining life is not driving the request. Although there is not a hint of these concerns in this case, the best way to ensure that those involved in the petition are in fact working toward the best interests of the child is to open the hearing to public scrutiny.

****932** The need for open proceedings is particularly compelling where an agency of the executive branch of government seeks to persuade the judicial branch of government to withdraw life support. Decisions of this gravity, made with this concentration of government involvement, should be made in public. Withdrawal of life support does not arise solely in the context of a care and protection proceeding. It may arise on a petition of a hospital in the Probate and Family Court or the Superior Court. See, e.g., *Matter of Rena*, 46 Mass.App.Ct. 335, 705 N.E.2d 1155 (1999). Such a hearing would be open to the public unless closed after findings are made conformably with the Uniform Rules on Impoundment Procedure (2005). There is no reason to treat these hearings differently simply because the Department of Social Services is involved.

When care and protection proceedings were first closed to the public by St.1954, c. 646, § 1, this issue probably had not been anticipated. The most extreme case to arise in the twenty-four years that followed involved an order to provide life-sustaining medical treatment contrary to the parents' wishes. See *Custody of a Minor*, 375 Mass. 733, 379 N.E.2d 1053 (1978). Medical advances have changed the landscape but the statute remains unchanged. The issue warrants reexamination by the Legislature.

Mass.,2006.
In re Care and Protection of Sharlene
445 Mass. 756, 840 N.E.2d 918

END OF DOCUMENT

Attachments

[Appended to **Part Two: Post-Adoption, 2001-2005**]

DSS Response to "A Case Study within the Department of Social Services (DSS)"

MITT ROMNEY
Governor
♦
KERRY HEALEY
Lieutenant Governor
♦
TIMOTHY MURPHY
Secretary
♦
LEWIS H. SPENCE
Commissioner

The Commonwealth of Massachusetts
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Department of Social Services
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TO: Geoffrey Hall, Chairman
House Committee on Post Audit and Oversight

FR: Harry Spence, Commissioner

DA: June 13, 2006

RE: Addendum to 6/13/06 DSS Response to the House Post Audit and Oversight Report

On a further note, I would like to acknowledge that the Department continues to work with the Executive Office of Health and Human Services on the recommendations put forth by the Governor's Haleigh Poutre Panel.

Please accept this as an addendum to my response to the House Post Audit and Oversight Report. Thank you.

Observations on the Report of the
Committee on Post Audit and Oversight
of the
Massachusetts House of Representatives

Overview

The Massachusetts Department of Social Services has received the Report of the Committee on Post Audit and Oversight and reviewed it in the two working (four calendar) days allowed. The Committee clearly seeks to address the events described in the Report in a manner that will help "remedy the identifiable, systemic shortcomings and obstacles to child welfare." In a similar fashion, these observations are intended to contribute to a public dialogue about how best to increase the Commonwealth's capacity to ensure the "safety, permanency and well-being" of our children--the goals of child welfare for which the Department of Social Services is the primary instrument.

The Department is impressed by the thoroughness, precision, and integrity with which the Committee's investigative staff has approached this case. Its examination of the case has clearly been exhaustive. While we believe that some of the questions, comments, and conclusions of the Committee's Report suffer from the absence of broad knowledge and understanding of child welfare practice and context, we recognize the overall value of a fresh and unfettered examination of a child welfare case that ended in a terrible atrocity to a child.

The Report of the Committee is much stronger, however, in its analysis of the shortcomings of the Department's child welfare practice in this case than it is in its prescriptions for improvement. Even when precisely on point and compelling, its hundreds of pages of detailed case critique are hard to link to the ten recommendations of the Committee, summarized on a single page. Given the investigators' lack of knowledge of the child welfare system, this shortcoming is understandable. In their letter of transmittal, the investigators acknowledge the limitations of their product by enumerating the essential systemic questions left unanswered by their extensive commentary on this case:

> To be effective, this case study should be utilized as something more than a recitation of failures within a single tragic case. Rather, understanding the facts of this case can and should lead to the next step: constructive inquiry and response. That next step should ask: what do the facts of this case reveal about the DSS system? And, too, the system of child welfare beyond DSS? What questions should be raised about these systems based on fact-finding? What systemic practices should be confronted?

It is incumbent on the Department and its leadership to take up these questions concerning the systemic implications of the Committees' findings and to undertake the changes necessary to greatly strengthen practice.

While we obviously deplore the hysterical rhetoric of such editorial opinion as that appearing in the Boston Herald following the release of the Governor's Panel report in April ("Blow Up DSS"), the Department does believe that there must be a profound renovation of child welfare practice. We believe that the failures of child welfare will not surrender themselves to incremental change; the roots of those failures lie deep in the fundamental structures and culture of child welfare. We also concur with the Report's investigators that the knowledge and experience necessary to reshape child welfare primarily lies within the child welfare community itself. Indeed, the call for fundamental change in the way child welfare work is carried out comes most deeply and powerfully from within the Department and the child welfare field.

The Massachusetts child welfare department is generally recognized as one of the best in the nation. While vulnerable to the weaknesses that characterize all of child welfare, Massachusetts has also been a national practice leader in identifying important ways to improve child welfare work. We in Massachusetts therefore have a particular capacity and responsibility to challenge ourselves to deeply rethink how we do the work. For the past four years, the Department has been engaged in the most comprehensive critique and revisioning of child welfare practice underway in the nation today. This work is informed by both our understanding of the weaknesses and failings of the child welfare system and by an appreciation of the strengths and successes that the Department has achieved. Much of the change is being implemented today; much more is planned.

This document delineates the changes in child welfare practice that we are undertaking and describes how they address the critique offered in this and previous reports. We start with an analysis of the impediments to improvement that have historically stunted the growth and development of child welfare. Any effective strategy for change must start by addressing these impediments. We then identify what we believe to be the fundamental structural flaws in the ways child welfare work is traditionally practiced. Finally, we lay out the comprehensive strategy we are undertaking to correct those fundamental structural flaws, indicating, where appropriate, how our strategy seeks to address the failings identified—whether explicitly or implicitly—in the Committee's Report. We believe that our strategy for renovating child welfare practice at DSS incorporates many of the present and historic recommendations for practice improvement at DSS, but goes well beyond them to more fundamental structural renovation of the system.

In sum, we seek to incorporate valuable learning from your critique into our own, and in so doing, to offer you, the Legislature, our prescription for addressing the systemic failings of traditional child welfare practice. We hope it warrants your support for our

shared commitment to dramatically improving our service to the children and families of Massachusetts.

Why child welfare practice seems to improve so little and so slowly

The Report of the Committee on Post Audit and Oversight is the second such examination of the Department's work in the last three months, and one of many in the twenty-five year history of the Department. It is safe to say that no other Department has been examined and reported on by major public commissions and deliberative bodies as frequently or intensively as the Department of Social Services. This circumstance is not unique to Massachusetts; on the contrary, the same could be said of the great majority of child welfare departments in the nation. Child welfare is a consistent focus of investigation, diagnosis, intervention, and intended correction. Yet, we see no apparent cessation in the circumstances that are the source of public concern.

In this respect, the situation of child welfare in Massachusetts and nationally bears an eerie resemblance to the case described in this Report: frequent, intense, sustained surveillance and intervention in a distressing situation that seems to result in no marked change or improvement. As in the case of the Child under consideration, so in the case of child welfare more generally, we might pause and ask ourselves why our relentless examination and prescription for the patient is not resulting in the desired change.

In the hopes of escaping the fate of being just one more document in an endless succession that have had little impact on improving child welfare practice, we begin by addressing the question of why so many reports, inquisitions, recommendations, and examinations have not resulted in more substantial improvement in child welfare practice in Massachusetts and across the nation. If we simply proceed in manner of the past, we can expect that the Committee's report and this response will join the procession of official pronouncements on child welfare that have resulted in too little change, too late. On the other hand, if we can correctly identify and address the contextual factors that have impeded change in the past, we can proceed with hope that our altered circumstances can finally support significant change.

We identify six contextual challenges to significant learning and improvement in child welfare. For each, we also outline recent changes that hold the promise of addressing these challenges, providing hope that the current circumstances may be more propitious for change than those that have prevailed in the past.

1) The challenge of a punitive accountability system:

The growth and development of child welfare has been sharply stunted by the prevalence of punitive approaches to child welfare accountability. Child welfare systems are publicly called to account almost exclusively around incidents of atrocity

to a child. These incidents are the most acutely disturbing events that occur in the culture and rightly provoke horror and outrage. Unfortunately, the most common human response is to demand identification of someone responsible for the incident, which has led to a focus on individual caseworker culpability and punishment as the response to failure. The consequence of this approach is that failure has forced little attention to the deeper organizational structures and culture of child welfare, resulting in little systemic change. We have been firing child welfare staff and commissioners consistently across the nation for over two decades, with little apparent impact on the problem. As the old adage avers, insanity is doing the same thing over and over, expecting a different result. If we are to see meaningful improvement, we need to look beyond punitive accountability.

In a letter from the Commissioner to the Legislature of March 2001, the Department committed itself to moving from a punitive model to a learning model. In accordance with that commitment, the Commissioner has pledged to never scapegoat Departmental staff in high profile cases. This has not diminished accountability for performance, however, and the Department has not flinched from enforcing professional standards for performance.[1]

At the same time, both the Governor and the Legislature have refused to engage in punitive scapegoating. The Committee's own Report calls for a focus on systemic learning and change, rather than on individual blame. The federal Child and Family Service Reviews of state child welfare programs have a similar focus on organizational learning rather than punitive accountability. Finally, other states have recently adopted a learning rather than a punitive focus in their response to high profile cases (Connecticut offers a clear recent example in our own region).

2) <u>The challenge of the confidentiality defense</u>

Child welfare systems have too often invoked confidentiality as a protection against public disclosure of their failings. The press and public have rightly grown deeply suspicious of the confidentiality claim; nonetheless, the need to prevent the lives of children and families from becoming open to public prying and humiliation is real. The law of child welfare confidentiality has to be reconsidered. In the meantime, most child welfare systems are seeking to reconcile the competing claims of confidentiality and public accountability in a more sophisticated manner. Starting with former Commissioner Locke, DSS has sought to be more direct and open in response to public debate about its performance. But as a court contempt motion against the Massachusetts DSS commissioner in a recent high profile case attests, this is still uncertain territory for child welfare systems.

3) <u>The challenge of a closed professional system</u>

Child welfare work requires an unusual measure of physical and emotional courage, emotional resiliency, ability to confront trauma and pain, insight into human behavior, and dedication to the welfare of children. As a result, child welfare

[1] The Department's enforcement has resulted in thirty-eight voluntary and involuntary terminations in the past two years—a highest rate of professional discipline in EOHHS and in the history of the Department.

managers and supervisors tend to develop within the system, and only rarely enter the system from outside. While this practice fosters a high degree of dedication to the work, it also deprives child welfare of the wide array of experience and perspective that a more open recruitment system would provide. In consequence, professional orthodoxies often go unchallenged, since all senior managers have grown up in the some organizational culture and share the same professional training and experience. The strong clinical focus of the social work discipline also has historically meant that little attention has been given to organizational structures and systems in the child welfare field.

DSS has recently sought to solicit assistance from a broader array of experts from outside the child welfare field. Its dialogue with the educational community is well-advanced, and it is opening up a broader dialogue with the medical community. DSS has sought insight from nationally recognized experts on organizational behavior and psychology, to inform its change and improvement strategies.

4) <u>The challenge of confused expectations</u>

Child welfare suffers from being held up to judgment against at least three competing, even contradictory, public expectations, each of which commands intense commitment. The three competing expectations are:

- That child welfare organizations will prevent all atrocities to children, with zero tolerance for failure (the Atrocity Standard);
- That child welfare organizations will support distressed families to change, so that they are able to raise their children with diminished risk of harm, without unwarranted interference in the life of the family (the Therapeutic Standard);
- That child welfare organizations will intervene in the lives of abused and neglected children in such a way as to ensure that their life outcomes are not significantly worse than the outcomes of children who grew up without trauma (the Outcomes Standard).

The first of these standards, the Atrocity Standard, is the one that child welfare systems are judged against in the wake of a high-profile case. While the public rationally knows that crime prevention is an extraordinarily difficult task in a libertarian society, the horror provoked by atrocities against children often obscures that knowledge. A zero tolerance for failure, while rationally unachievable, seems the only possible response that does justice to our revulsion at atrocity against children. The current report, with its emphasis on investigation as the central work of the Department and its call for unrelenting skepticism with regard to all parental claims, illustrates the push to adversarial practice that high profile cases and an investigative focus prompt.

In contrast, the vast majority of the Department's work is with families in which there is no risk of intentional fatal or near-fatal violence to children. In these tens of thousands of cases, the Department's role is to diminish the risk of harm to the child by supporting the caregivers to improve their parenting (the Therapeutic Standard). Not surprisingly, the research is clear that success in this aspect of child welfare work, success depends on

developing a relationship of trust with caregivers—the opposite of the relentless skepticism that the Atrocity Standard seemingly demands. Outside of the infrequent high-profile events, the primary complaint against the Department--from lawyers, therapists, legislators, advocates and others--is that the Department is too adversarial and intrusive in its work with thousands of Massachusetts families. This complaint pushes the Department to seek more affiliation and partnership with families.

Finally, the Outcomes Standard, with its emphasis on ensuring a permanent family for every child, pushes the Department to minimize the trauma it inflicts in the course of its work, so as to encourage the best possible life chances for the child. This standard fosters a practice more in line with the Therapeutic Standard, minimizing intrusive and adversarial practice and the trauma associated with the removal of a child from its family.

The tension and conflict among these competing standards for child welfare work has often left child welfare organizations bewildered as to how to achieve public approval for their work, and caroming among the three contradictory expectations without a clear or coherent understanding of mission.

In recent years, child welfare has begun to clarify its response to these conflicting expectations, primarily through the development of differential response systems in child welfare. These systems, which are discussed below, differentiate the response of the child welfare system to a child and family, based on the level of risk which the child and family present. We believe that differential response holds great promise for mediating among the conflicting expectations the Department faces.

5) The challenge of the complexity of the work

Child welfare work is the most complex and demanding work that state or local governments undertake. The task of observing the most distressed and complex families, predicting their future behavior, and supporting them to change for the sake of their children is unmatched in difficulty by any other public activity. Threatened with public outrage for their failures, child welfare organizations have often sought to "dumb down" the work, reducing the enormous judgment and discretion inherent in the work to a few readily enforceable standards subject to easy monitoring for compliance. Unfortunately, the core competencies of the work--judging risk, diagnosing family dynamics, fostering behavior change, supporting healing—are not amenable to being "dumbed down."

The work requires the development of individual competencies and organizational capacities as complex as the dynamics of the children and families that child welfare deals with. The Department's strategy for revising child welfare practice has built in sturdy organizational supports for increasing our capacity to carry out complex child welfare practice, through greatly expanded training and professional certification, through Continuous Quality Improvement and Quality Service Reviews, and other measures. Already, as a result of Family Networks, observers have recognized the increasing customization of treatment plans to meet the varying and complex needs of children and families.

6) The challenge of applying systematic measures of performance

Given the considerable confusion about the standards for judging child welfare, and the complexity of the work, it is not surprising that child welfare has been slow to develop systematic measures of its performance. This situation has left no way to measure the Department's performance except by the Atrocity Standard: how often do high profile cases involving death or near-death events appear in the newspaper? The child welfare system's success or failure in supporting the great majority of the families it encounters, and the outcomes for children who have been involved with the Department, are invisible. In these circumstances, how can the public possibly judge whether the Department is achieving "safety, permanency and well-being" for the children it is involved with?

The development of a powerful and complex IT system in the Department over the past several years finally allows the Department to deploy outcome-based performance measures. These measures are being incorporated into a comprehensive Continuous Quality Improvement system, which allows not only the Department, but providers, parents and family, and community leaders to measure the Department's success in achieving safety, permanency and well-being.

* * *

All of these forces have historically conspired to keep child welfare from developing and improving in the ways that its obligation to children and families and to the citizenry would require. Trapped in a defensive crouch, obsessed with staying out of trouble, buffeted by contradictory public expectations, child welfare across the nation has often stumbled from crisis to crisis in a self-fulfilling prophecy of failure. The Massachusetts child welfare system, like others across the country, has begun to diagnose the challenges to system learning and growth, and to understand the hapless cycle of failure that child welfare has too often been trapped in. As child welfare systems and the contexts they operate in begin to address these challenges to improvement, the hope for genuine system renovation increases.

The structural impediments to more effective child welfare practice

Over the last four years, the Massachusetts Department of Social Services has taken up the challenge of profoundly rethinking its child welfare practice. In doing so, it has sought to step out of all inherited organizational orthodoxies, while learning deeply from its own and the nation's child welfare experience, both successes and failures. Staff throughout the Department have been extensively involved in this process; the work of renovation has been the work of the entire Department, not just of senior management. But more, the work has reached out beyond Departmental staff to the entire system of care for children who have suffered abuse and neglect: private providers, foster and adoptive parents, youth and families previously involved with the child welfare system, and community partners, such as school staff, police, medical personnel, staff of other human services departments. In addition, we have invited researchers, child welfare

experts, and other states to share in our deliberations on the redesign of child welfare in Massachusetts. In a number of aspects of our reinvention work for Massachusetts, we have drawn on successful experience in other parts of the country. Always, we have sought to advance the learnings further as we adapt that successful experience to our own situation. Sometimes, we have invented anew, and contributed major new learning to the national child welfare enterprise.

In the course of this reinvention work, we have identified six major structural failings in the current organization of child welfare work. These six are obviously not exhaustive; there are multiple causes of the problems of child welfare. But they are the key structural failings that help to organize our efforts to reinvent the practice of child welfare:

1. The core work processes in child welfare are organized around an inappropriate universal model: the individual social worker responsible for observation, analysis and decision-making with regard to children and family;
2. Child welfare engages all families and allocates staff resources according to a single, undifferentiated procedure, regardless of the level of risk posed to the children in their family and community setting;
3. Child welfare has historically failed to incorporate critical new learning, particularly with regard to intervention and treatment, into its practice;
4. Child welfare has not measured and monitored the data most central to its achievement of its goals;
5. Child welfare has most often found itself isolated from its natural partners in the care and protection of children: families, providers, day care and schools, medical and behavioral health care professionals, and community organizations;
6. Child welfare has often been unable to accord the measure of attention to families required by the goals of child welfare, due to the economy of resources built into caseload standards.

These six critiques of the structure of traditional child welfare practice together constitute the core diagnosis that underlies our restructuring of child welfare in Massachusetts. Some of this critique is anticipated in the several commissions and studies of DSS of the past two decades; some is new and arises from our ongoing reexamination of our child welfare practice. We are currently engaged in a multi-year process that will fundamentally redesign our structures and processes in response to this critique, building on the learnings and strengths derived from recent decades of child welfare practice in Massachusetts and elsewhere.

A model for redesigning child welfare practice in Massachusetts

In order to reveal how our strategy for change is grounded in our critique of traditional child welfare practice, we will start by discussing the changes we are undertaking as responses to each of the six critiques described above. In the process, we will discuss how the changes address the shortfalls in Departmental practice suggested in the Committee's report. We will then array the many structural changes we have undertaken

into a strategic model for system change, illustrating the feedback loops that will drive continuous improvement in child welfare practice. Finally, we will append an independent, third party narrative commissioned by the Marguerite Casey Foundation and Casey Family Services, describing the process of change underway in DSS today. We hope this will provide the Legislature and the public with an understanding of the strategy for comprehensive renovation of child welfare practice that we are engaged in.

1. The core work processes in child welfare are organized around an inappropriate universal model: the individual social worker responsible for observation, analysis and decision-making with regard to children and family.

Child welfare work requires observation, analysis and decision-making concerning the most distressed and complex families in the Commonwealth. The Department is charged with understanding the dynamics of these families sufficiently to assess both near-term danger and longer-term risk. We must then intervene to reduce danger and risk to children, most frequently by supporting families to change their behaviors sufficiently to ensure the safety and well-being of their children. Historically, child welfare organizations have devolved responsibility for these extraordinarily complex and imponderable decision processes to a single isolated social worker. Yet we know from innumerable organizational studies that the quality of observation, analysis and decision-making is significantly improved by involving multiple persons with multiple perspectives in such complex processes (hence the 6, 9 and 12 person jury process). In addition, the emotional stress of child welfare work is more intense than almost any other work. High stress results in poor decision-making, overwhelm and high turnover, all compounded by worker isolation.

In response to this understanding, Massachusetts has initiated the first effort in the country to develop a core child welfare work process based on team responsibility for "cases". This effort has been funded by a $1million grant from the Marguerite Casey Foundation. As a result of the Massachusetts initiative, New York State has begun experiments in team assignment and responsibility for cases, and the two states are applying to the Annie E. Casey Foundation to obtain support for a shared learning process to refine the organizational model for conducting child welfare work on a team structure. Massachusetts has been asked to describe its teaming model in the Journal of the American Public Human Services Association (see attachment), and has been selected from among over one thousand applications as one of eighteen finalists for this year's Kennedy School of Government Innovations in Government Awards. Winners will be announced July 10, 2006.

There is evidence throughout the Committee's report that the fragmentation of responsibility for child welfare work results in critical evidentiary patterns being missed. The Committee's investigators have been able to assemble data that remained isolated in the knowledge of one or another among multiple autonomous social workers, to reveal patterns that would have prompted greater skepticism concerning the mother's statements, had those patterns been perceived. Obviously, the investigators had

advantages and resources that no child welfare system can have in the course of its work: they knew the outcome of the case, they knew the malefactors, they knew the patterns to look for, and they had the extraordinary luxury of almost unlimited time and opportunity to assemble and deeply ponder an entire case history, recorded by social workers and collaterals over a period of years. While no child welfare practice can ever have the luxury of so much time and so many knowns in the course of its work; nonetheless, the investigators powerfully demonstrate how the disaggregation of information across multiple, isolated social workers over time diminishes the capacity of child welfare systems to penetrate the intentional deceptions that characterize this and other atrocity cases. We are confident that teaming will increase the chances that disparate data points will be regularly connected through team deliberation in a team-based child welfare practice. We have preliminary evidence that the give and take inherent in team responsibility for cases improves the quality of decision-making, diminishes idiosyncratic practice and increases the sense of ownership and responsibility for all aspects of a case

In addition, it is clear from the case under review that the traditional structure of child welfare investigation is singularly ill-equipped to penetrate the kind of elaborate deception that misled so many medical and clinical personnel in this case. In traditional child welfare, investigation can only be triggered by individual complaints of abuse or neglect, and is conducted by a single investigator. Due to caseload, the average investigation is limited to roughly two and one half days, dramatically curtailing comprehensive investigation with multiple data sources (collaterals) at one point in time. Again, we believe that a teaming design (especially when combined with differential response [see below]) will empower significantly more effective investigation when appropriate in a case.

For these and many other reasons evident in our teaming practice, we believe that team responsibility for child welfare cases greatly improves the quality of child welfare practice and supports improved partnership with our natural partners in child welfare. We are hopeful that it will in time become the accepted organizational model for all child welfare practice throughout the nation.

2. Child welfare engages all families and allocates staff resources according to a single, undifferentiated procedure, regardless of the level of risk posed to the children in their family and community setting.

Currently in Massachusetts, every family that comes to the Department's attention through a complaint of abuse or neglect is treated in a uniform fashion: Screening, followed by investigation, assessment and ongoing case management. The result is that essentially the same kind and level of staff resource is applied to the very low risk neglect case as is applied to high risk abuse cases. The Department has no formal structure to apply Departmental resources in accordance with the level of risk to the child that we encounter. As a consequence, we over-allocate resources to low risk cases and under-allocate resources to high risk cases.

Additionally, by making no differentiation in our response to different types of family, our core practice is a mix of investigative skepticism with regard to caregiver representations and therapeutic affiliation and partnership with parents. The two approaches are in constant, confusing tension, diminishing our capacity to investigate perceptively and to partner appropriately.

In the last decade, eleven states have experimented with a dramatically revised approach to the allocation of child welfare resources, known as "differential response." Differential response systems provide two different tracks for families involved with the child welfare system through allegations of abuse or neglect: one track is reserved for those families where the presenting circumstances of the family suggest a high risk of subsequent harm to the child; the other track is followed where the risk of future harm is less. Greater investigative and assessment resources can be applied to the higher risk cases. The lesser risk track, in contrast, appropriately emphasizes affiliation and partnership with the family, according significantly greater weight to the family's own diagnosis of their difficulties in child rearing. The result of this collaborative approach with families is that improvement in parenting proceeds more swiftly and is more sustained.

The research on differential response is now extensive enough to demonstrate its effectiveness. The Minnesota research, in particular, has been rigorous and thorough, and reveals both much greater satisfaction with differential response, both by families and workers, and improved safety outcomes for children. As a result of our examination of differential response systems over the past year, we have authorized a design group to design a differential response plan for consideration by the larger Massachusetts system. The design group, of both departmental staff and other stakeholders, is now at work. At this point in time, it appears that some aspects of a differential response system that we might contemplate will require legislative authorization. We look forward to further discussions with the Legislature as our planning proceeds.

Central to the success of differential response is the adoption by the child welfare system of reliable safety and risk assessment tools. The Department recently convened a conference on safety and risk assessment tools, involving the differential response design team, the Children's Research Bureau, sponsor of the most developed and thoroughly researched tool, Structured Decision Making, and Vermont and Ohio, states which have implemented this tool. We are discussing with the Children's Research Bureau how their tools might be customized to the needs of Massachusetts.

The Committee's Report makes clear that serial, single person investigations, triggered only by successive injuries to a child are a weak tool for penetrating complex and confusing patterns of injury, like those that prevailed in this case. The Committee recommends extending the statutory time frame for investigations from ten calendar days to fifteen. We agree, but believe we must reorganize our investigative and assessment activities more fundamentally than this.

While single person investigations triggered by reports of injury or harm may be sufficient for the great majority of child welfare cases, there are some few, which often contain the greatest risk of atrocity, that require a very different approach. First, we believe that the current system, in which a reexamination of risk only occurs in response to a new allegation of abuse or neglect, depends too much on external contingency for safety reassessment. In a differential response system, utilizing safety and risk assessment tools, safety and risk assessment occurs at regular intervals (usually every three months), regardless of subsequent complaint. More than this, we believe that the Department must be able to initiate a multi-person, team-based process of investigation and assessment when uncertainty about the safety of a child warrants. This process could allow for swift, intensive examination of the circumstances of a family, with multiple collateral contacts, resulting in the assembling of a wide array of data on the child's situation. It would allow the Department to utilize a process similar to that which the Committee's investigators were able to employ: assembling multiple data elements from disparate sources in a single, comprehensive review. We believe such a process holds greater promise of discovering the reality when facing unusual complexity or in the rare instance of persistent caregiver deceptiveness.

3. Child welfare has historically failed to incorporate critical new learning, particularly with respect to intervention and treatment, into its practice

The last twenty years of behavioral health research has witnessed the development of several new interventions and treatments with children and young adults that have been demonstrated to be highly effective in treating child behavioral problems. These interventions and treatments are not dependent on traditional talk therapy, not do they rely on psychotropic drugs. They are genuine behavioral interventions that generally involve training child and caregivers in more effective ways to manage emotion and behaviors that otherwise threaten the well-being of child and community. The effectiveness of these interventions and treatments has been rigorously tested in large scale trials with control groups, making them qualify as true evidence-based practices.

Unfortunately, these evidence-based practices have not been widely implemented in either child welfare or other elements of the behavioral health system. For example, Dr. William Beardsley of Harvard Medical School has developed a behavioral intervention for assisting children in families in which a caregiver suffers from clinical depression. A recent study revealed a caregiver suffering clinical depression in over 50% of the child welfare families studied. Dr. Beardsley's treatment has been successfully implemented among health care providers in Finland, but not yet in Massachusetts, much less in a DSS area office only blocks from Dr. Beardsley's office.

In the last three years, with the support of the Administration and Legislature, DSS has formed the Massachusetts Child Welfare Institute, a collaboration among the Department, the Salem State School of Social Work and the University of Massachusetts Medical School at Worcester. As a result of the establishment of the Child Welfare Institute, the Department is eligible to receive federal Title IVE reimbursement for child welfare training expenses. The professional development budget of the Department has increased

from $400,000 per year for 3400 employees to $3 million (and we hope that in FY 07 it might be raised to $4 million).

The Committee's Report recommends significant improvements in social work training for child welfare. We are pleased that through our collaboration with Salem State, we can work to further strengthen academic training for child welfare at the State's only accredited MSW program. However, we believe that a more direct route to practice improvement is through the Department's own professional development programs. We are in the process of developing a child welfare certification program to replace the current social work licensing program, since the latter is a generic social work license with only glancing attention to child welfare. The child welfare certification curriculum for DSS supervisors is designed and will be required of all DSS supervisors, after negotiation with the Department's union representatives. At the same time, over forty Area Office managers and staff have recently completed a nine-month curriculum in family-centered, solution-focused practice at the Cambridge Family Institute, one of the preeminent centers of family practice training in the country. In all, over one thousand employees of the Department received training through the Child Welfare Institute in the past year. Our goal is to provide ten days of professional development annually to every employee.

It is important to note that the Institute does not serve only Department employees. We have established two other Centers within the Institute: one for providers and one for paents and families. With tuition from provider organizations, the Provider Center has already offered a nine month professional development program to the COO's of residential provider organizations in conjunction with the implementation of Family Networks. We are collaborating with the nationally recognized Trauma Center in the development of a curriculum on evidence-based practice for providers. These are only examples of the comprehensive curriculum development and training that will in time be offered by the Child Welfare Institute, in collaboration with Salem State and UMass Medical School.

At the same time, the Department has entirely redesigned its purchased service system, and is implementing a comprehensive system of care management and community-based child welfare through its Family Networks system. Through Family Networks, the Department is actively fostering the adoption of evidence-based practices by the Commonwealth's provider network. For example, we are bringing Youth Villages, a nationally recognized provider of Multi-Systemic Therapy (MST), to Massachusetts, both to provide MST themselves and to train local providers in the use of MST. MST is perhaps the most celebrated and successful of the evidence-based practices, with an extensive proven record in resolving the problem behaviors of adolescents in both the child welfare system and the juvenile justice system.

Boston is home to many of the nation's preeminent researchers in child and family behavioral health: Dr. William Beardsley, Dr. Jack Shonkoff, Dr. Joanne Nicholson, Dr. John Weisz and others. All have demonstrated an intense interest in assisting the Department to bring the best and most current knowledge to its practice. The Department

is committed to making the Child Welfare Institute the finest professional development center for child welfare in the nation. Historically, Massachusetts child welfare staff have been better trained than the staff of most other states. Nonetheless, that standard is inadequate; Massachusetts' child welfare system of care should be the most advanced in the nation, given the quality of our researchers, providers and staff. We are on course to achieve that goal.

4. Child welfare has not measured and monitored the data most central to its achievement of its goals.

During the decade of the 1990's, child welfare developed its first robust data systems. Those systems captured the data that the technology of the era could capture: data on timely compliance with organizational procedures. While that data may have had some value in bringing more consistent timeliness to child welfare practice, it added little or no value in the core work of child welfare: assessing safety and risk, analyzing family dynamics, devising effective intervention and treatment, supporting caregiver behavior change.

We are today the fortunate inheritors of more complex data systems. The Department's IT system can today generate data that allows us to measure not just procedural compliance, but actual outcomes for children. We are able to assess the frequency of safety failures in our practice, the incidence of placement instability, the number of children who achieve permanence and how long it took.

As a consequence of our more powerful and robust data systems, we have anchored our strategy for practice improvement in a Continuous Quality Improvement (CQI) system. Every office—Area, Regional and Central—has established a CQI committee, composed of staff, providers, parents and family and community leaders. These committees have begun to examine a few critical outcome measures for that office, and analyze the strengths and weaknesses of their local practice, based on those measures. Six offices have volunteered to pilot the next phase of CQI, and will start working in the fall with multiple, more complex measures of outcome and performance. Area, Regional and Central Offices will compare our individual assessments of the local office's strengths and weaknesses. Out of that, we will develop an agreed-upon, customized strategy for practice improvement in that office, and will monitor progress in that strategy through outcome data.

But the work of the Committee points to the need for a more concise, fine-grained assessment of the Department's child welfare practice. The investigators' detailed critique of the many micro-decisions that constitute practice in a single case yields important insights into the quality of practice. These insights could not be extracted from data alone.

In its CQI system, the Department has provided for that kind of qualitative case review, through the use of the Quality Service Review (QSR) process. Some twenty case records

are selected at random from the case files of a local Area Office. The cases are extensively reviewed, according to a precise standard QSR protocol by a team of Department staff from outside that office. The quality of case practice is then recorded by scoring practice in the several key domains of practice. Improvement in practice can then be measured over time, by examining the trend in scores for that office. A design team is currently working with the inventor of the QSR process to customize protocols for use by the six pilot offices this fall.

The emerging CQI system subjects the Department's practice to continuous review for improvement, using both quantitative and qualitative measures of practice effectiveness. While the QSR reviews can never be as intensive as the Committee's review of this case, nonetheless, the quality of case practice can be assessed, and progress in improvement objectively determined.

5. Child welfare has most often found itself isolated from its natural partners in the care and protection of children: families, providers, day care and schools, medical and behavioral health care professionals, and community organizations.

In order for treatment to be effective with children and families, there must be alignment among the primary participants in the family's life. When child welfare and a school system fail to communicate, or worse, are at odds over the treatment plan for a child, the effectiveness of the treatment is blunted. Similarly, when there is lack of accord among DSS and the medical professionals serving a family, effectiveness falters. Unfortunately, the model of the isolated social worker has often been mimicked in the isolated posture of the child welfare organization towards its organizational peers.

In order to foster alignment among the critical participants in a family's life, Family Networks has initiated the use of Family Team Meetings to coordinate the work of all the key actors in a family's life: school personnel, behavioral health providers, medical personnel, community organizations. Family Team Meetings are being introduced particularly for children with more serious behavioral problems, where coordination among multiple care providers is especially important. Family Team Meetings are convened and coordinated by staff of the newly established Area Lead Agencies, on behalf of the Department, at regular intervals.

The Committee's Report documents the failures of communication between the treatment team and the Department in the Child's case. These failures deprived DSS of essential information, that could have hastened the recognition that treatment was not enhancing the family's capacity to keep the child safe. While Family Team Meetings could not guarantee that all the participants in the Child's life would be forthcoming with crucial information, it would have provided a consistent forum for communication and coordination. Family Team Meetings would have increased the odds that a tragedy might have been averted.

The Family Team Meetings introduced through Family Networks unquestionably improve care coordination and treatment planning for families involved in child welfare.

They also increase the likelihood that essential information is shared among all the participants in a child's life, thereby reducing risk to children.

6. Child welfare has often been unable to accord the measure of attention to families required by the goals and expectations for child welfare, due to the economy of resources built into caseload standards.

To do child welfare work with the meticulousness suggested in the Committee's Report requires a dramatic reduction in caseload. A social worker with a caseload of 18 families, the standard for the department, has a minimum of thirty-six people to keep track of at all times. Even with a caseload of eighteen, social workers are often dealing with sixty to seventy-five children and adults simultaneously. It is impossible to imagine that any social worker could maintain the kind of precise, detailed command of every aspect of a family's complex life that the investigator's achieve when they examine a single family's case for weeks and months.

If we aspire to a more precise, meticulous child welfare practice in Massachusetts, we will have to dramatically lower caseloads. Two factors determine caseload: 1) The number of social work personnel, and 2) Caseload management. The Legislature and the Governor decide the resources that will be afforded to support social work personnel and the supervisory and administrative structure they require. The Department has therefore focused its energy on improving caseload management.

It is important to note that caseload management is a dimension of the Department's safety responsibility. When caseloads increase, safety for children is further compromised. There is a natural tendency in all organizations for the work to expand to fill the resource allotted to it. If management of caseloads is not consistently attended to, caseload will always continue to expand to consume whatever social work resources are accorded to the Department. Keeping caseloads at a safe level, therefore, requires that sufficient staff be assigned to the Department, and that the management of their caseloads be carefully maintained.

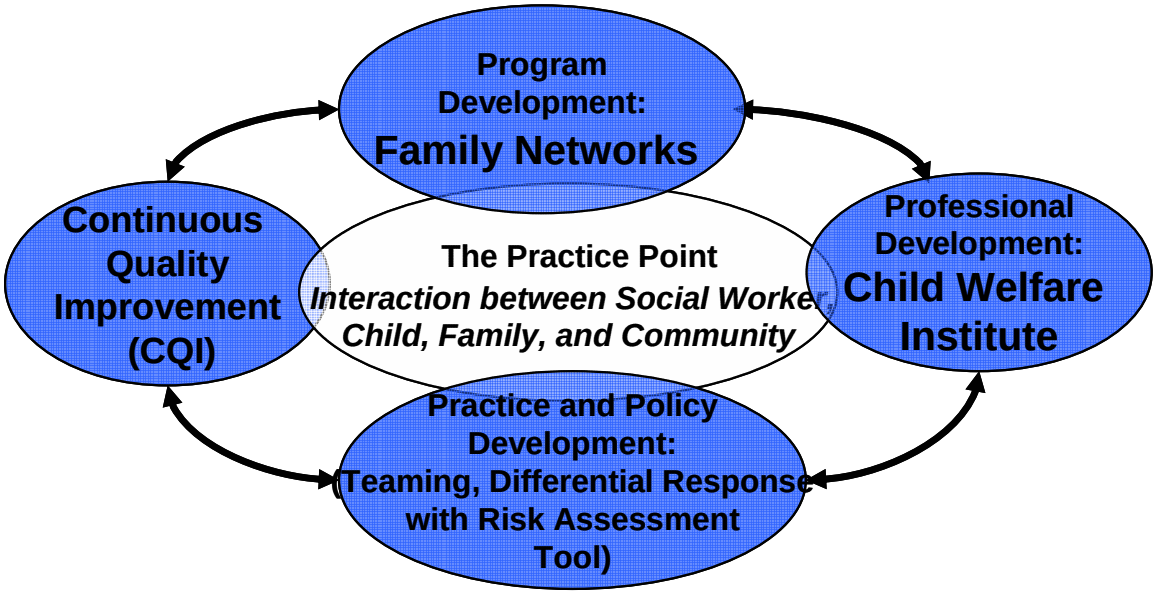
Caseload is determined not simply by the number of cases opened and closed, but by the flow of cases through the Department. If reasonably sustainable safety for a child can be achieved in six months on average, the Department will be able to function with half the social workers necessary, if it takes a full year to ensure safety. Child welfare practices that reduce the time a case must be with the Department also serve to reduce caseload, allowing more precise and effective casework to be performed. Preliminary evidence suggests that teaming reduces case duration, due to the work efficiencies achieved through teaming and the improved relationship with families. In similar fashion, Family Networks should favorably impact case duration, and therefore caseload, as a result of the speed and intensity with which services can be mobilized, and the improved coordination of those services.

Certain offices in the state have a sustained record of compliance with the caseload maximums. Many others have more volatile caseload histories. The Department is currently codifying the practices that allow certain offices to manage caseload successfully, in order to share those practices with offices that have not yet mastered caseload management.

A strategic model for system change

The elements of system change presented above as a response to the structural flaws of traditional child welfare can be arrayed as a strategic model for system change. We call this model "the integration map." It presents each of the major elements of system change in a graphic chart, illustrating the feedback loop that drives continuous improvement in the system.

The Integration Map



There are five major elements to the improvement strategy we are undertaking:

1. Continuous Quality Improvement (CQI)
2. Family Networks
3. Massachusetts Child Welfare Institute
4. Differential Response with Risk Assessment Tool
5. Teaming

These five major elements are arrayed around the Practice Point, the point where the social worker meets the family. The entire strategy has only one purpose: to impact the practice point, where child welfare practice succeeds or fails in achieving safety, permanency and well being.

Continuous Quality Improvement anchors our strategy: constant assessment of the quality of our practice, based on quantitative outcomes and qualitative practice review. This CQI process will inform the development of a practice improvement strategy for each Area Office.

There are three primary areas for practice improvement:

1. Program development to initiate or enhance a service essential to treatment;
2. Professional development to strengthen practice among staff of DSS, providers or families;
3. Practice and policy development, to bring best practice or evidence-based practice to our work.

Each element of our strategy for improvement enhances our capacity in one of these three areas:

1. Family Networks enhances our capacity for program development;
2. The Massachusetts Child Welfare Institute enhances our capacity for professional development;
3. Differential response with a risk assessment tool, and teaming enhance our capacity for practice and policy development.

The CQI process drives our improvement strategy and then measures whether improvement is resulting from the strategy. This is the feedback loop that drives continuous improvement.